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**Rules of  
Office of Administration**

**Division 10—Commissioner of Administration  
Chapter 15—Cafeteria Plan**

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**Title 1—OFFICE OF  
ADMINISTRATION  
Division 10—Commissioner of  
Administration  
Chapter 15—Cafeteria Plan**

**1 CSR 10-15.010 Cafeteria Plan**

*PURPOSE: This rule complies with the statutory requirement that the commissioner file a written plan document in accordance with Chapter 536, RSMo, and payroll deduction qualifications in accordance with Chapter 33, RSMo.*

(1) The cafeteria plan for state employees, authorized by section 33.103, RSMo, shall contain the following items:

(A) A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost, premium or health savings account contribution for coverage under any state sponsored health plan which provides medical benefits or health insurance to or on behalf of any employee or spouse or dependent in the event of illness or personal injury to the employee or spouse or dependent, which plan or program is available to the employee by reason of his/her status as an employee;

(B) A provision authorizing the payment through the cafeteria plan, pursuant to a separate but related flexible medical benefits plan, established in conjunction with the cafeteria plan, of amounts expended by a participating employee for medical care of the employee or spouse or dependent, which amounts are not covered or reimbursable to the employee from any other source;

(C) A provision authorizing the payment or reimbursement through the cafeteria plan of employment-related expenses for the care of a spouse or dependent of a participating employee, pursuant to a separate but related dependent care assistance plan of the state, established concurrently with the cafeteria plan;

(D) A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost or premium for coverage under any state sponsored health plan which provides dental benefits or dental insurance to or on behalf of any employee or spouse or dependent, which plan or program is available to the employee by reason of his/her status as an employee;

(E) A provision authorizing the payment through the cafeteria plan of a participating employee's share of the cost or premium for coverage under any state sponsored health plan which provides vision care benefits or vision care insurance to or on behalf of any

employee or spouse or dependent, which plan or program is available to the employee by reason of his/her status as an employee; and

(F) A provision authorizing a participating employee to reduce his/her future compensation for purposes of participation in the cafeteria plan.

(2) The commissioner of administration shall maintain the cafeteria plan, in written form, denominated as the *Cafeteria Plan for the Employees of the State of Missouri* included herein.

(3) Voluntary payroll vendors whose products meet the qualifications of Section 125 of Title 26 of the United States Code and section 33.103, RSMo must meet the following criteria for solicitation of business on state property:

(A) The vendor's product must already be qualified by the Office of Administration;

(B) The vendor may only present the products that qualify under Section 125 of Title 26 of the United States Code and section 33.103, RSMo;

(C) The vendor must schedule solicitation visits with each building manager at least one (1) week in advance. Building managers may make more restrictive policies regarding locations and times of visits as long as the restrictions do not prohibit access to state facilities;

(D) The vendor must not interrupt employee work time for presentation of products or services or other solicitations;

(E) The vendor may not utilize employee representatives to distribute product information;

(F) All marketing materials must have prior approval by the Office of Administration prior to distribution;

(G) Each vendor must state to employees that their product is not endorsed by the state of Missouri as a state provided benefit and include such statement on all marketing materials; and

(H) Any vendor violating any one (1) of these criteria may lose their payroll deduction privilege.



APPENDIX A  
MISSOURI STATE EMPLOYEES' CAFETERIA PLAN DOCUMENT

**Cafeteria Plan  
for the Employees of  
the State of Missouri**

**Plan Document**

Effective January 1, 2016  
(with an original effective date of January 1, 1992)



**Cafeteria Plan  
for the Employees of  
the State of Missouri**

**Plan Document**

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Section 1  
Introduction

1.1 Establishment of the Plan

The State of Missouri (the “Employer”) hereby amends the State of Missouri Cafeteria Plan (the “Plan”) effective January 1, 2016(the “Effective Date”). The original Plan was effective January 1, 1992.

1.2 Purpose of the Plan

This Plan allows an Employee to participate in the following Benefit Options based on his/her eligibility status as stated in Section 4:

- **Premium Payment Plan (PPP)** to make pre-tax Salary Reduction Contributions to pay the Employee’s share of the premium or contribution for the Health Plan, Dental Plan, and/or Vision Plan.
- **Health Flexible Spending Account (Health FSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.
- **Limited Scope Health Flexible Spending Account (Limited Scope Health FSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of Dental and Vision Expenses.
- **Dependent Care Assistance Program (DCAP)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.
- **Health Savings Account Contribution Benefit (HSA Contribution Benefit)** to make pre-tax Salary Reduction Contributions to a Health Savings Account.

1.3 Legal Status

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

The **Health FSA** and the **Limited Scope Health FSA** are intended to qualify as self-insured health reimbursement plans under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees’ gross income under Code §105(b).

The **DCAP** is intended to qualify as a dependent care assistance program under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees’ gross income under Code §129(a).

The **HSA Contribution Benefit** is intended to meet all requirements of §223 of the Code.

Although reprinted within this document, the **Health FSA**, the **Limited Scope Health FSA**, the **DCAP** and the **HSA Contribution Benefit** are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The **Health FSA** and the **Limited Scope Health FSA** are also separate plans for purposes of applicable provisions of COBRA and HIPAA.



**1.4 Capitalized Terms**

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this document or in other relevant Sections. When reading the provisions of the Plan, please refer to the Glossary at the end of this document. Becoming familiar with the terms defined there will provide a better understanding of the procedures and Benefits described.



**Section 2**  
**General Information**

<b>Name of the Cafeteria Plan</b>	State of Missouri Cafeteria Plan
<b>Name of Employer</b>	State of Missouri
<b>Address of Plan</b>	Office of Administration, P.O. Box 809, Jefferson City, MO 65102-0809
<b>Plan Administrator</b>	State of Missouri/Office of Administration
<b>Plan Sponsor and its IRS</b>	State of Missouri/Office of Administration
<b>Employer Identification Number</b>	44-6000987
<b>Named Fiduciary &amp; Agent for Service of Legal Process</b>	State of Missouri
<b>Type of Administration</b>	The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the State of Missouri Cafeteria Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. State of Missouri may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
<b>Plan Number</b>	501
<b>Benefit Option Year</b>	The twelve-month period ending December 31 (with an additional 2 ½ month grace period).
<b>Plan Effective Date</b>	January 1, 2016, with an original effective date of January 1, 1992
<b>Claims Administrator</b>	Application Software, Inc., dba ASI, dba ASIFlex
<b>Plan Renewal Date</b>	January 1
<b>Internal Revenue Code and Other Federal Compliance</b>	It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
<b>Discretionary Authority</b>	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.



In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section -- Section 2.





## Section 3

**Benefit Options and Method of Funding****3.1 Benefits Offered**

Each Employee may elect to participate in one or more of the following Benefits based upon his/her eligibility as stated in Section 4:

- **Premium Payment Plan (PPP)** as described in Schedule A.
- **Health Flexible Spending Account (Health FSA)** as described in Schedule B.
- **Health Savings Account Contribution Benefit (HSA Contribution Benefit)** as described in Schedule C.
- **Dependent Care Assistance Program (DCAP)** as described in Schedule D.
- **Limited Scope Health Flexible Spending Account (Limited Scope Health FSA)** as described in Schedule E.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

**3.2 Employer and Participant Contributions**

- **Employer Contributions.** The Employer may, but is not required to, contribute to any of the Benefit Options. There are no Employer Contributions for the **PPP** under this Plan; however, if the Participant elects the **PPP** as described in Schedule A, the Employer may contribute toward the Health Plan, Dental Plan and/or Vision Plan as provided in the respective plan or policy of the Employer.
- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

**3.3 Computing Salary Reduction Contributions**

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:
  - The annual election for such Benefits payable on a semi-monthly or monthly basis in the Period of Coverage;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)



- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the **PPP, Health FSA, Limited Scope Health FSA, or DCAP**, as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:
  - An amount equal to:
    - The new annual amount elected pursuant to the Method of Timing and Elections section below;
    - Less the aggregate Contributions, if any, for the period prior to such election change;
    - Payable over the remaining term of the Period of Coverage commencing with the election change;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.
- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.
- **After-Tax Contributions for PPP.** After-tax Contributions for the Health Plan will be paid outside of this Plan.

### 3.4 Funding This Plan

- **Benefits Paid from General Assets.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as claims payments and enrollment.
- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan



Administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.

- **Maximum Contributions.** The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the **PPP** as described in Schedule A, **Health FSA** as described in Schedule B, **HSA Contribution Benefit** as described in Schedule C, the **DCAP** as described in Schedule D, and the **Limited Scope Health FSA** as described in Schedule E.



Section 4  
**Eligibility and Participation**

**4.1 Eligibility to Participate**

**Any Employee** (see definition of Employee as set forth in the glossary) may participate in the DCAP benefit.

**Any Benefit Eligible Employee** (see definition of Benefit Eligible Employee as set forth in the glossary) may participate in all benefit options for this plan.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

**4.2 Required Salary Reduction Agreement**

To participate in the **Health FSA, Limited Scope Health FSA, or DCAP**, an Employee must complete, sign and return to the Plan Administrator a Salary Reduction Agreement by the deadline designated by the Plan Administrator. If an Employee fails to return a Salary Reduction Agreement, the Employee is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the Employee experiences an event permitting an election change mid-year.

The Employee may begin participation on the 1st of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the Enrollment requirements each year.

**4.3 Termination of Participation**

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;
- The termination of this Plan; or
- The date on which the Employee ceases to be an eligible Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year.

**False or Fraudulent Claims.** The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits. In addition, an Employee filing a false or fraudulent claim is subject to disciplinary action, up to and including termination of employment.



Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms thereof.

#### 4.4 Rehired Employees

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within 30 days or less of the date of termination of employment, the Employee will be reinstated with the same elections that the Participant had prior to termination. If the Employer rehires a former Participant within the same Plan Year but more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

#### 4.5 Eligibility Rules Regarding the Health FSA

A Benefit Eligible Employee enrolled in a Health Savings Account (HSA) is not eligible to enroll in the **Health FSA** but is eligible to enroll in the **Limited Scope Health FSA**. **An Employee is only allowed to enroll in either the Health FSA or the Limited Scope Health FSA, not both.**

#### 4.6 Eligibility Rules Regarding the HSA Contribution Benefit

An Employee must be an HSA Employee to elect to participate in the **HSA Contribution Benefit Plan**.

Only Employees who satisfy the following conditions may be considered an HSA Employee:

- Covered under a qualifying High Deductible Health Plan (HDHP) maintained by the Employer;
- Opened an HSA with the custodian chosen by the Employer;
- Not covered under any other non-HDHP maintained by one Employer that is determined by the Employer to offer disqualifying health coverage;
- Not claimed as a tax dependent by anyone else;
- Not enrolled in Medicare coverage; and
- Eligible to participate in the Plan.

#### 4.7 FMLA Leaves Of Absence

**Health Benefits.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA then to the extent required by FMLA, the Participant will be entitled to continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:



- With after-tax dollars, by sending monthly payments to the Employer's designee by the due date established by the Employer;
- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any; or
- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, 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 (notwithstanding the Grace Period provision). However, see Sections B.7, D.8, and E.7 for information regarding the Grace Period for participants who terminate coverage.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Contributions will be equal to the amount withheld prior to the period of FMLA leave.

**Non-Health Benefits.** If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as **DCAP** Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. 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 shall 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.

#### 4.8 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, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.



#### 4.9 Death

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the date of death. A Participant may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

#### 4.10 COBRA

Under the COBRA rules, as discussed in the attached Schedules B and C, where applicable, the Participant's Spouse and Dependents may be able to continue to participate under the **Health FSA** through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

#### 4.11 USERRA

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.



Section 5  
**Method of Timing and Elections**

### 5.1 Initial Election

An Employee must complete, sign and return a Salary Reduction Agreement within the election-period set forth therein to enroll in the Benefit Options, other than the **PPP**.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the 1st day of the month coinciding with or after the date the Employee completes, signs and returns a Salary Reduction Agreement or completes a Salary Reduction Agreement using the electronic system produced by the Employer (if any), within the election period set forth therein.

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option (see Glossary for definition). The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit Options.

### 5.2 Open Enrollment

During each Open Enrollment Period, the Plan Administrator shall make available a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete sign and return the Salary Reduction Agreement or complete an election using the electronic system provided by the Employer, if any, to the Plan Administrator on or before the last day of the Open Enrollment Period. There is an exception of automatic elections in the **PPP**.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

The Employer may, in lieu of a Salary Reduction Agreement, provide an electronic method for Employees to use to make elections. The Employer may require Employees to use the electronic system to make elections. Use of an electronic system will have the same effect as a signed Salary Reduction Agreement.

### 5.3 Failure To Elect

If an Employee fails to complete, sign and return a Salary Reduction Agreement or fails to complete an election using the electronic system (if any) provided by the Employer within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash (excluding the **PPP**). The Employer provides for an automatic election for the **PPP**, therefore, the Employee will have also agreed to a Salary Reduction for such Employee's Contribution to the **PPP**.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or





- Until an event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.



**Section 6**  
**Irrevocability of Elections and Exceptions**

**6.1 Irrevocability of Elections**

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section.

The irrevocability rules do not apply to the **HSA Contribution Benefit** election.

The rules regarding irrevocability of elections and exceptions are quite complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance.

**6.2 Procedure for Making New Election If Exception to Irrevocability Applies**

- **Timing for Making New Election if Exception to Irrevocability Applies.** A Participant may make a new election within 30 days of the occurrence of an event described in section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Health Plan shall automatically result in a corresponding election change, whether or not requested.
- **Effective Date of New Election.** Elections made pursuant to this Section shall be effective on the 1st of the month following or coinciding with the Plan Administrator's receipt and approval of the election request 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 "Certain Judgments, Decrees and Orders" or 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.
- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document.
- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the **Health FSA, Limited Scope Health FSA, or DCAP** also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
  - Any Contributions made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election; to
  - The total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Benefit Option; reduced by
  - All reimbursements made during the entire Period of Coverage.



6.3 **Change in Status Defined**

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation or annulment;
- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the **DCAP**, a change in the number of Qualifying Individuals as defined in Code §21(b)(1);
- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:
  - A termination or commencement of employment;
  - A commencement of or return from an unpaid leave of absence;
  - A change in worksite; or
  - If the eligibility conditions of this Plan or another employee benefit plan of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;
- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and
- **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

6.4 **Events Permitting Exception to Irrevocability Rule**

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Option.

The following rules shall apply to all Benefit Options except where expressly limited below.

- **Open Enrollment Period.** A Participant may change an election during the Open Enrollment Period.



- **Termination of Employment.** A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.
- **Leave of Absence.** A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.
- **Change in Status.** *(Applies to the PPP, Health FSA, Limited Scope Health FSA, and DCAP as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and 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 also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

The Plan Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. 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 elections based on the specified Change in Status:

- **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, 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 plan, dental plan, and/or vision plan coverage for:
  - The Spouse involved in the divorce, annulment, or legal separation;
  - The deceased Spouse or Dependent; or
  - The Dependent that ceased to satisfy the eligibility requirements.

Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under the Employer's plan, then the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate 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.

- **Special Consistency Rule for DCAP Benefits.** With respect to the **DCAP**, the Participant may change or terminate the Participant’s election upon a Change in Status if:
  - 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
  - The election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.
  
- **HIPAA Special Enrollment Rights** (*Applies to the PPP only*). If the Participant, the Participant’s Spouse or Dependent is entitled to special enrollment rights under a group health plan as required by HIPAA, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds with such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:
  - The Participant, Spouse or Dependent declined to enroll in group health plan coverage because the Participant, the Participant’s Spouse or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or 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;
  - The Participant acquired a new Dependent as a result of marriage, birth, adoption or placement for adoption; or
  - The Employee or Dependents who are eligible but did not enroll for coverage when initially eligible and:
    - The Employee or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
    - The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

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 due to birth, adoption, or placement for adoption of a new Dependent child may, subject to the group health plan, be effective retroactively for up to 30 days.

- **Certain Judgments, Decrees and Orders.** (*Applies to the PPP, Health FSA, Limited Scope Health FSA, but does not apply to the DCAP*). If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child



Support Order (QMCSO) requires accident or health coverage, including an election for **Health FSA** Benefits for a Participant's Dependent child, a Participant may:

- Change an election to provide coverage for the Dependent child provided that the order requires the Participant to provide coverage; or
- Change an election to revoke coverage for the Dependent child if the order requires that another individual provide coverage under that individual's plan and such coverage is actually provided.
- **Medicare and Medicaid.** (*Applies to the PPP, Health FSA, Limited Scope Health FSA, but does not apply to the DCAP*). If a Participant, Spouse or Dependent is enrolled in a Benefit under this Plan and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Health Plan covering the person, and the **Health FSA** coverage may be cancelled but not reduced. However, such cancellation will not be effective to the extent that it would reduce future contributions to the **Health FSA** or the **Limited Scope Health FSA** to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the **Health FSA** or the **Limited Scope Health FSA** coverage.
- **Change in Cost.** (*Applies to the PPP and DCAP as limited below, but does not apply to the Health FSA or the Limited Scope Health FSA*). For purposes of this Section, "similar coverage" means coverage for the same category of Benefits for the same individuals.
- **Insignificant Cost Changes.** The Participant is required to increase his or her elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options, and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants' elective Contributions on a prospective basis.
- **Significant Cost Increases.** If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:
  - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;
  - Revoke the election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or



- Terminate coverage going forward if there is no other Benefit Option available that provides similar coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant.

- **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit (such as the premium for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:
  - Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective contributions by decreasing Salary Reductions;
  - Participants who are enrolled in another benefit package option may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or
  - Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.
- **Limitation on Change in Cost Provisions for DCAP Benefits.** The above “Change in Cost” provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.
- **Change in Coverage.** (*Applies to the PPP and DCAP, but not to the Health FSA or the Limited Scope Health FSA*). The definition of “similar coverage” applied in the Change of Cost provision above also applies here.
- **Significant Curtailment.** Coverage under a Plan is deemed to be “significantly curtailed” only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is “significantly curtailed,” Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a “Loss of Coverage” as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is “significant,” and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.
  - **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant’s coverage under a Benefit Option (or the Participant’s, Spouse’s or Dependent’s coverage under the respective employer’s plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Option if offered, that provides similar coverage.
  - **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant’s coverage under this Plan (or the Participant’s, Spouse’s or Dependent’s coverage under the respective employer’s plan) is significantly curtailed,



and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit Option that provides similar coverage or drop coverage if no other Benefit Option providing similar coverage is offered by the Employer.

- **Definition of Loss of Coverage.** For purposes of this Section, a “Loss of Coverage” means a complete loss of coverage. In addition, the Plan Administrator in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage:
  - A substantial decrease in the health care providers available under the Benefit Package Plan;
  - A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
  - Any other similar fundamental loss of coverage.
- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:
  - Participants who are enrolled in a Benefit Option other than the newly-added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and
  - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Option.
- **Loss of Coverage Under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, 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 children’s health insurance program (CHIP) under Title XXI of the Social Security Act;
  - A health care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization;
  - A state health benefits risk pool; or
  - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.





- **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:
  - 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
  - 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.

The Plan Administrator, on a uniform and consistent basis, will decide whether a requested change is because of, and corresponds with, a change made under the other employer plan.

- **Enrollment in a Group Health Plan that Offers Minimal Essential Coverage or in a Health Care Exchange or Marketplace.** An Employee may make a **prospective** election change that is on account of and corresponds with a change to his/her PPP election, so long as:
  - The Employee's employment status changes from an expectation to work 30 hours or more per week to an expectation to work less than 30 hours per week (even if that change fails to make the Employee ineligible for Employer-sponsored group health plan coverage); AND the Employee enrolls in a group health plan that offers minimal essential coverage (as defined by the Affordable Care Act) with a new coverage effective date no later than the first day of the second month following the month that includes the date the original coverage is revoked; or
  - The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or the Employee seeks to enroll in a Marketplace during the Marketplace's annual open enrollment period; AND the Employee enrolls in the Marketplace with a new coverage effective date no later than the day immediately following the last day the original coverage is revoked.
- **Change in Dependent Care Service Provider.** A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:
  - If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and
  - If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

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



### 6.5 Election Modifications for HSA Contribution Benefits May be Changed Prospectively At Any Time

As set forth in Schedule C, an election to make a Contribution to an **HSA Contribution Benefit** can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no later than the 1<sup>st</sup> day of the next calendar month following the date that the election change was filed. No other Benefit Option election changes can occur as a result of a change in an **HSA Contribution Benefit** election except as otherwise permitted in this Section.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures established by the applicable participating Employer or Health Plan.

### 6.6 Election Modifications Required by Plan Administrator

The Plan Administrator may require, at any time, any Participant or class of Participants to amend their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;
- 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;
- Maintain the qualified status of Benefits received under this Plan; or
- Satisfy any of the Code's 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.



**Section 7**  
**Claims and Appeals**

**7.1 Claims Under the Plan**

If a claim for reimbursement under the **Health FSA, Limited Scope Health FSA, or DCAP** is wholly or partially denied, or if the Participant is denied a Benefit under the Plan regarding the Participant's coverage under the Plan, then the claims procedure described below will apply.

**7.2 Notice from ASI**

If a claim is denied in whole or in part, ASI will notify the Participant in writing within 30 days of the date that ASI received the claim. This time may be extended for an additional 15 days for matters beyond the control of ASI, including cases where a claim is incomplete. ASI will provide written notice of any extension, including the reason(s) for the extension and the date a decision by ASI is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Participant at least 45 days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

**7.3 First Level Appeal to ASI**

If a claim is denied in whole or in part, the Participant, or the Participant's authorized representative, may request a review of the adverse benefits determination upon written application to ASI. The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 90 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.



#### 7.4 ASI Action on Appeal

ASI, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. ASI may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal ASI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

#### 7.5 Second and Final Level Appeal to the Plan Administrator

If the decision on review affirms ASI's initial denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse appeal determination must be made in writing within 30 days after receipt of the notice that the first level appeal was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the prior determination.

#### 7.6 Plan Administrator Action on Appeal

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the prior claim denial. The identity of any



medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the decision on review;
- The specific Plan provision(s) on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

#### 7.7 Appeal Procedure for Eligibility or Salary Reduction Issues

If the Participant is denied a Benefit under the Plan due to questions regarding the Participant's eligibility or entitlement for coverage under the Plan or regarding the amount the Participant owes, the Participant may request a review upon written application to the Plan Administrator.

The Participant, or the Participant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited unless otherwise protected by law. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 30 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and



- Appropriate information on the steps to take to appeal the Plan Administrator’s adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

If the decision on review affirms the Plan Administrator’s denial, the Participant may request a review of the adverse appeal determination upon written application to the Plan Administrator. The Second and Final Level of Appeals Procedures described above will apply.

**Section 8**  
**Plan Administration****8.1 Plan Administrator**

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

**8.2 Powers of the Plan Administrator**

The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions hereunder. The Plan Administrator shall have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters hereunder. The Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan (provided that the Plan Administrator shall exercise such exclusive power with respect to an appeal of a claim);
- To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- 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;
- 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;
- To furnish each Employee and Participant with such reports in relation 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;
- To receive, review and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- 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;
- 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;



- To secure independent medical or other advice and require such evidence as deemed necessary to decide any claim or appeal; and
- 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.

### 8.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the Participant's direction, information or election 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 the 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.

### 8.4 Outside Assistance

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Plan Administrator.

### 8.5 Insurance Contracts

The Employer and/or some of the related employers adopting this Plan may have the right to enter into a contract with one or more insurance companies or self-fund for the purposes of providing any Benefits under the Plan; and to replace any of such insurance companies, contracts, or benefits. 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.

### 8.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act.

### 8.7 Inability to Locate Payee

If the Plan Administrator is unable to make payment to the Participant or another person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or such other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to the Participant or such other person shall be sent to the state's unclaimed property division.





**8.8 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Participant's account, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, correct by making the appropriate adjustments of such amounts as necessary to credit the Participant's account or such other person's account or withhold any amount due to the Plan or the Employer from Compensation paid by the Employer.



**Section 9**  
**Amendment or Termination of the Plan**

**9.1 Permanency**

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in the paragraphs below.

**9.2 Right to Amend**

The Employer reserves the right to merge or consolidate the Plan and to make any amendment or restatement to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Participant.

Any amendment or restatement shall be deemed to be duly executed when properly promulgated under the requirements of Chapter 536.

**9.3 Right to Terminate**

The Plan Administrator reserves the right to discontinue or terminate the Plan in whole or in part at any time without prejudice. A related employer has the right to discontinue participating in the Plan at the end of each calendar year.



**Section 10**  
**General Provisions**

**10.1 No Contract of Employment**

Nothing contained in the Plan shall be construed as a contract of employment with the Employer or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee, with or without cause.

**10.2 Compliance with Federal Mandates**

To the extent applicable for each Benefit Option, the Plan will provide Benefits in accordance with the requirements of all federal mandates, including USERRA, COBRA, and HIPAA. 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.

**10.3 Verification**

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee or Dependent. If the Participant does not supply the requested information within the applicable time limits or provide a release for such information, the Participant will not be entitled to Benefits under the Plan.

**10.4 Limitation of Rights**

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provided herein or as provided by law.

**10.5 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.

**10.6 Governing Law**

This Plan is intended to be construed, and all rights and duties hereunder are governed, in accordance with the laws of the State of Missouri, except to the extent such laws are preempted by any federal law.