# Summary Plan Description

## MEMPHIS-SHELBY COUNTY AIRPORT AUTHORITY
## SECTION 125 FLEXIBLE BENEFITS PLAN

### SUMMARY PLAN DESCRIPTION

### INTRODUCTION

We are pleased to announce that we have restated our Section 125 Flexible Benefits Plan (the "Plan") for you and other eligible employees. Under this program, you will be able to choose among certain Benefits that we make available. The Benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the Benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our Plan and the Benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a Participant. You should direct any questions you have to the Administrator. There is a Plan Document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an Insurance Contract and either the Plan Document or this Summary Plan Description, the Insurance Contract will control.

# I

# GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

**GENERAL PLAN INFORMATION**

**1.** Memphis-Shelby County Airport Authority Section 125 Flexible Benefit Plan is the **Name** of the Plan.

**2.** The original provisions of your Plan were effective on February 15th, 2011, which is called the **Effective Date** of the Plan.

The effective date of this **Restatement** is January 1st, 2019.

**3.** Your Plan's records are maintained on a 12-month period of time. This is known as the **Plan Year.** The Plan Year begins each January 1st and ends each December 31st.

**4.** Your Employer has assigned **Plan Number** 501 to your Plan.

**5. Employer Information**

Memphis-Shelby County Airport Authority Federal Tax ID: 62-1262331

2491 Winchester Road, Suite 113

Memphis, TN 38116-3856

(901) 922-0192

**Affiliated Employer Adopting This Plan**:

**6. Plan Administrator Information**

The name, address, and business telephone number of your Plan's **Administrator** is:

Memphis-Shelby County Airport Authority Federal Tax ID: 62-1262331

2491 Winchester Road, Suite 113

Memphis, TN 38116-3856

(901) 922-0192

The Administrator keeps the records for the Plan and is responsible for the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

**7. Service of Legal Process**

The Administrator is the Plan's agent for service of legal process.

**8. Type of Administration**

The type of Administration is Employer Administration.

**9. Eligibility Requirements**

All Employees who are otherwise eligible to participate in the Employer's group health plan shall be eligible to participant in the Plan, **except**:

- Under the Health Savings Account, individuals who fail to qualify as an Eligible Individual for a Health Savings Account under Code Section 223(c);
- With the exception of the Health Savings Account program, any self-employed person(s), within the meaning of Code Section 401(c), including independent contractors, a greater than 2% shareholder in a Subchapter S corporation, a partner in a partnership, or any owner or member of a limited liability company that is treated like a partnership for tax purposes;
- A relative, within the meaning of IRC Section 318, of one of the above self-employed person(s)
- AND/OR:

  ☐ Part-time employees expected to work less than _____hours per week.

  ☐ Employees under the age of _____ years.

  ☐ Contract Employees (Appointed Staff)

  ☑ Any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers unless the collective bargaining agreement requires the employee to be included within the Plan.

  ☑ Any Employee who is temporary or seasonal (working for the Employer less than 6 months of the year).

  ☑ Any Leased Employee, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.

**10. Plan Entry Date/Waiting Period**

Employees eligible to participate may become participants:

☑ On the first day of the month, after

☑ 30 days of continuous service (but subject to shorter limitation period if mandated under applicable law).

**11.** Under our Plan, you can choose to receive your entire Compensation or use a portion to pay for the following **Benefits** or expenses during the year:

The following Benefit Options shall be included in the Plan:

- ☑ Healthcare Flexible Spending Account subject to an annual limit of $ 2,700.00.
  (IRS $2,700 maximum may be indexed each year to reflect any anticipated cost of living adjustments as assigned by the IRS.)
- ☐ Limited Purpose (limited to vision and dental) Healthcare Flexible Spending Account subject to an annual limit of $_____ ($2,700 IRS maximum).
- ☑ Dependent Care Assistance Program subject to the maximums contained in Section 7.9 of the Plan Document.
- ☐ Adoption Assistance Program subject to the maximums contained in Section 8.9 of the Plan Document.
- ☑ The employer's payroll-deducted health insurance (including dental and vision insurance).
- ☑ The employer's payroll-deducted group term life insurance (premium for the first $50,000 in coverage only).
- ☐ Employee Health Savings Account Contributions, subject to the terms and conditions of Article X of the Plan Document.

The applicable cost for any of these selected Benefits, enumerated above, will be paid for within each Participant's applicable Flexible Benefits Plan Dollars Account.

**12. Contributions:**

The contributions for this Plan shall be:

- ☑ Employee (Salary Redirection) contributions only.
- ☐ Employer Contributions of:

**13. Maximum Contributions:**

a) The maximum amount you can contribute to the Healthcare Flexible Spending Account each Plan Year shall be $ 2,700.00 . (The IRS maximum of $2,700 may be indexed annually to reflect any cost-of-living adjustments as deemed necessary).

b) The Plan ☑ shall ☐ shall not provide for a carryover of $ 500.00 [Maximum $500] of any amount remaining unused in a Healthcare Flexible Spending Account as of the end of the Plan Year (subject to the limitations set forth under Section 6.4(c) of the Plan Document).

c) The maximum amount you can contribute to the Dependent Care Assistance Plan each Plan Year (or calendar year) shall be the lesser of: 1) $5,000 (if you are married, filing a joint return or single and head of a household) or $2,500 (if you are married, filing separate returns); 2) your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse which is a full-time student or incapable of self-care has monthly earned income of $250 for one dependent or $500 for two or more dependents).

**14. Claims Incurred During the Claims Extension Period**

☐ Shall ☑ Shall not include the provision for "Claims Extension Period".

**15. Claims Reimbursements**

Employees shall have ninety (90) days after the end of each Plan Year to submit requests for reimbursement for expenses incurred during the Plan Year.

***Terminated employees*** will be allowed to file claims for a period of forty five (45) days following the date of their termination. Expenses must have been incurred during the employee's period of coverage in order to be considered for reimbursement.

**16. Payment of HSA Medical Expenses During Claim Extension Period N/A**

The Plan ☐ shall ☐ shall not allow an Employee to be considered as an Eligible Individual, for HSA participation purposes, to enable payment of HSA Medical Expenses during any applicable Healthcare Flexible Spending Account Claim Extension Period (provided such Employee had a "zero balance" in his or her Healthcare Flexible Spending Account as of the end of the prior calendar year, or other applicable conditions set forth under applicable law).

**17. Expense Allocation and Order of Benefit Payment N/A**

If the Employer sponsors a Healthcare Flexible Spending Account and/or a Health Reimbursement Account (HRA) in addition to a Health Savings Account for Eligible Employees, eligible Medical Expenses under the Healthcare Flexible Spending Account and/or an HRA shall:

☐ Only include expense payments for vision and/or dental (limited benefit) coverage under a Limited Purpose Healthcare Spending Account, which can be paid before or commensurate with the Health Savings Account (but based on the ordering rules of the HRA Plan if a Healthcare Flexible Spending Account is also provided); or

☐ Be paid *after* the Health Savings Account.

II

# ELIGIBILITY

## 1. When Can I Become a Participant in the Plan?

Before you become a member or a "Participant" in the Plan, there are certain rules that you must satisfy. First, you must meet the eligibility requirements. After that, the next step is to actually join the Plan on the Entry Date that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Plan. Please refer to Section I, "General Information About Our Plan" of this document for a description of the Entry Date for our plan.

## 2. What are the Eligibility Requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the eligibility requirements under this Plan. Please refer to Section I, "General Information About Our Plan" of this document for a description of our eligibility requirements.

## 3. When is my Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

## 4. Are there any Employees Who are not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. Please refer to Section I, "General Information About Our Plan" of this document for a description of ineligible employees.

## 5. What Must I do to Enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the Benefits that are being offered under the Plan. You must also authorize us to set aside some of your earnings to pay for a portion of the Benefits you have elected.

However, if you are already covered under any of the insured Benefits, you will automatically participate in this Plan to the extent of your Premiums, unless during the Election Period, you elect not to participate in the Plan.

# III

# OPERATION

## 1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts, which must be set up for you in order to pay for the Benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal or Social Security taxes and in most cases State income taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you would normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

# IV

# CONTRIBUTIONS

## 1. Will my employer make contributions to the Plan on my behalf?

Your Employer may choose to make contributions to the Plan to assist you in offsetting the cost of Benefits offered under the Plan. These Employer Contributions are referred to as "Flexible Benefits Plan Dollars." Please refer to Section I, "General Information About Our Plan," to determine what, if any, amount your Employer has indicated it will contribute towards the cost of your Benefits under this Plan.

## 2. How much of my pay may the employer redirect?

To the extent your Employer either does not provide Flexible Benefits Plan Dollars to this Plan or the cost of Benefits offered under the Plan are greater than the Flexible Benefits Plan Dollar amount provided by your Employer, you may make an election, known as a Salary Redirection, to make additional pre-tax contributions to the Plan from your own Salary amount. Each year, for the insured Benefits provided under this Plan we will automatically contribute on your behalf enough of your Compensation to pay for the insurance coverage provided. In addition, you may elect to pay for the Benefits that you elect under the Plan. These amounts will be deducted from your Compensation each pay period on a pro rata basis over the course of the year.

## 3. How is my compensation measured under the Plan?

Compensation under our Plan means the total cash amount that is paid to you each year.

## 4. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the Benefits you want and how much of the contributions should go toward each Benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered Benefit or expense during the Plan Year. Later, they will be used to pay for expenses as they arise during the Plan Year.

## 5. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the Election Period. You must decide two things. First, which Benefits you want, and second, how much should go toward each benefit.

If you are already covered by any of the insured Benefits offered by this Plan, you will automatically become a Participant to the extent of the Premiums for such insurance unless, during the Election Period, you elect not to participate in the Plan.

## 6. When is the “Election Period” for our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your Entry Date. (You should review Section I, “General Information About Our Plan” and Section II, "Eligibility" to better understand the terms “eligibility requirements” and “Entry Date.”) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See Section I, “General Information About Our Plan” for the definition of “Plan Year.”)

## 7. May I change elections during the Plan Year?

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change if you have a “change in status,” you make an election change that is consistent with the change in status, and provided your request for change is made within 30 days from the date of change in status. Any new election will be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. Currently, Federal law considers the following events to be changes in status:

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

b) **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

c) **Change in Employment and/or Eligibility Status**. Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection. Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status;

d) **Other Employment Status Changes**. A change in the employment status of the Participant where the individual has been in an employment status under which the individual was reasonably expected to average at least 30 hours of service per week and there is a change in that individual's status so that the individual will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Plan, but only if the revocation of the election of coverage of under the Plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked;

e) **Anticipated enrollment in Qualified Health Plan**. A situation in which the Participant is eligible for a Special Enrollment Period to enroll in a "Qualified Health Plan" through a competitive marketplace established under § 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace ("Marketplace") pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or in which the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period, but only if the revocation of the election of coverage under the Plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked;

f) **Changes in one of your dependents** who satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or a similar circumstance;

g) **Changes in health plan access due to a change in residence or worksite** by you, your spouse, or a dependent that affect eligibility for benefits;

h) **Changes due to judgment, decree, or order resulting from divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order**. You may also change an election to cancel coverage for the child if the order requires a former spouse to provide coverage for such child and such coverage is actually provided.

i) **Changes due to entitlement to Medicare or Medicaid.**

j) **Changes due to entitlement to health insurance continuation coverage**, as prescribed under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended; application of the Family and Medical Leave Act of 1993 ("FMLA"); or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended.

k) **Other.** Such other events that the Administrator (in its sole discretion) determines to be consistent with and attributable to a change in status. Additional proof may be required by the Administrator to support any change of status election submitted by a Participant.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, the Salary Redirection election you have made for the remainder of the Plan Year if there is a change in the premium expense. If there is an increase or decrease in premium expense that is significant, we will let you either make corresponding changes to the Salary Redirection election or allow you to revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may change or revoke your election. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly added option, elect another option if an option has been eliminated, or revoke your election. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Healthcare Flexible Spending Account, and you may not change your election to the Healthcare Flexible Spending Account if you make a change due to cost or coverage for insurance.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be your qualified dependent will qualify as a change in status. However, you may not change your election under the Dependent Care Assistance Program if it is due to a cost change, and a dependent care provider who is your relative imposes that change. You may, however, change your election under the Dependent Care Assistance Program if there is a cost change imposed by a non-related dependent care provider.

For the Adoption Assistance Program, a commencement or termination of an adoption proceeding will also qualify as a change in status.

Under current rules, there are no special provisions or other criteria for any type of qualified change in status circumstances under the Tax-Free Transportation Plan or Health Savings Account Program. Accordingly, changes to any existing elections to these plans will not be considered for these programs, unless described under any other specific provisions described elsewhere in this document or the Plan itself.

There may be other events considered to be a change in status as determined by the IRS Regulations. There are detailed rules on when a change in election is deemed to be consistent with a change in status. If you have any type of change in status, you should contact the Administrator, who will provide you with the required forms for changing your benefit elections.

The Administrator makes the determination of whether a valid change of status has occurred. In making this determination, the Administrator has the authority to require additional evidence to support your stated reasons for changing any prior benefit election.

## 8. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, you will be considered to have elected to have a portion of your pay redirected for the upcoming Plan Year for the Premium Expense and/or Tax-Free Transportation Program portion(s) of this Plan only. You would not be considered a Participant for the Healthcare Flexible Spending Account, the Dependent Care Assistance Account, Adoption Assistance Account, or Health Savings Account portions of the Plan without completion of new elections prior to the beginning of the subsequent Plan Year.

## 9. How does the Family and Medical Leave Act (FMLA) affect this Plan?

Generally, if you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your benefits under this Plan on the same terms and conditions as though you were still an active Employee. If you take a paid leave under the FMLA, you may participate in annual enrollment, and you will be required to continue coverage while on FMLA, your share of the Premiums being paid by the method normally used during any paid leave. If you take an unpaid leave under the FMLA, you may revoke or change your existing elections for health insurance and the Healthcare Flexible Spending Account, and participate in annual enrollment.

Or, your employer may choose to continue coverage on your behalf during your FMLA leave. In such situations, you would be entitled to receive reimbursement of any qualifying expenses that you incurred during your FMLA leave period. However, if you continue your coverage during your unpaid leave, you may continue to make payment for coverage under one of the following methods:

a) **Prepayment.** Under the prepayment option, you can increase your Salary Redirection in an amount sufficient to cover the Premiums and other expenses that will come due during the FMLA leave.

b) **Pay-as-you go.** With the pay-as-you-go option, you must continue to pay Premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while on FMLA leave, the applicable Premiums are to be paid with pre-tax contributions as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid, the Administrator provides the funding for necessary coverage during the FMLA period, but you are required to reimburse the Employer at regular intervals with after-tax funds for the Premiums that come due during the leave.

c) **Catch Up.** The Administrator provides the funding for necessary coverage during the leave and subsequently withholds “catch-up” amounts from your pay upon your return.

Upon return from such leave that has been or is being paid for under one of the methods referred to above, you will be permitted to re-enter the Plan on the same basis as you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

If your coverage in these Benefits terminates, due to your revocation of the Benefit while on leave or due to your non-payment of contributions, your coverage will be reinstated for the remaining portion of the Plan Year upon your return. However, for the Healthcare Flexible Spending Account, if your coverage terminates due to your revocation of the benefit while on leave or due to your non-payment of contributions, two options will be offered upon your return:

a) **Proration.** The actual amounts contributed by you would remain available for your use the duration of the Plan Year, but the expenses you incur during that lapse in coverage would not be reimbursable and your maximum contribution amount would be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900; or…

b) **Reinstatement.** You may elect to reinstate the level of coverage in effect when the leave began, with your maximum contribution level remaining the same as previously elected. Any deficiencies in contributions will be made up when you return based on a payment schedule that is established by your employer. You will not, however, be entitled to receive reimbursement of any expenses that you incur during any previous lapse in coverage.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

## 10. How does the Uniformed Services Employment and Reemployment Rights Act (USERRA) affect this Plan?

If you are going into or returning from military service, you may have special rights to healthcare coverage under your Healthcare Flexible Spending Account and under the Health Savings Account, pursuant to USERRA. These rights can include extended healthcare coverage. If this law may affect you, ask your Administrator for further details.

## 11. What happens if I don't spend all Plan contributions?

It depends on the program in which you are enrolled. For example, if you are enrolled in either a Tax-Free Transportation Plan or a Health Savings Account, any unused amounts will be carried over to the next Plan Year and will generally be available for use in future years.

However, with respect to other Benefit options, subject to the applicable filing deadlines discussed in Article V, any contributed monies left at the end of the Plan Year will generally be forfeited. Having said this, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, if your Plan has adopted a Claims Extension Period (also known as an extended Grace Period) as further described within Section IX below, you have the additional period specified within Section I, "General

Information About Our Plan", to incur claims for you or your Dependents and still receive reimbursement for the Prior Year under the Plan. However, under all circumstances, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year or by the end of the month following the end of the Claims Extension Period deadline.

In addition to the general rule above, you may also have an opportunity to carry over up to $500 of any unused amounts in your Healthcare Flexible Spending Account to the next Plan Year if otherwise permitted by the Plan. More information about the payment of reimbursable expenses, payments or allowable carryovers of any other unused amounts is further discussed in Section V.

Because a number of different options are available to you and it is possible that you might forfeit amounts in the Plan if you do not fully use or rollover any allowable contributions that have been made, it is important that you decide how much to place in each account carefully before the Plan Year begins. You want to be as certain as possible that the amount you decide to place in your accounts will be used entirely. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

# V

# BENEFITS

## 1. What benefits are available?

Under our Plan, you can choose to receive your entire compensation in cash or use a portion to pay for certain other benefits or expenses during the year. The benefits or expenses that are available for payment under the Plan have been selected by your Employer and are identified under Section I, "General Information About Our Plan," referring to the Plan of Benefit Options. Notwithstanding the individual benefit selections that are available to you under your Plan, a discussion of pertinent issues that impact some of the more common benefit alternatives follows:

**Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain Premium Expenses under various Insurance Programs that we offer you. Please refer to Section I, "General Information About Our Plan," Plan of Benefit Options, for information on Insurance Programs for which Premium Expenses can be paid for by our Plan.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any Insurance Contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after 1) you have provided the Administrator the necessary information to apply for insurance, and 2) the insurance is in effect for you.

**Healthcare Flexible Spending Account**

The Healthcare Flexible Spending Account enables you to pay for expenses that are not covered by our health plan(s) and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental, and vision expenses incurred by you, your spouse, and your dependents. A medical expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when you are formally billed for, or are charged or, or pay for the medical care. The medical expenses, including any expense for medical care, which qualify are those permitted by Section 213(d) and Section 105 of the Internal Revenue Code and the rulings and Treasury Regulations thereunder. A list of covered expenses is available from the Administrator. Please note that you may not, however, be reimbursed for the cost of other healthcare coverage maintained outside of the Plan, or for long-term care insurance coverage or expenses nor will any over-the-counter drug expenses be reimbursed under the Plan unless prescribed by a licensed physician or except as permitted by law.

If you are an Eligible Individual who participates and makes contributions to a Health Savings Account, as discussed below, if your Plan allows as provided under Section I, "General Information About our Plan", you may elect to participate in a Limited Purpose Healthcare Spending Account, and receive reimbursement for qualifying dental or vision expenses only. You may otherwise be reimbursed in the same amounts and under the same periods as any other Healthcare Flexible Spending Account.

Please refer to Section I, "General Information About Our Plan" for the maximum amount that you can contribute to your Healthcare Flexible Spending Account each Plan Year. The maximum annual contribution amount that may be allocated to the Health Care Flexible Spending Account Benefit may not exceed the lesser of your salary reduction elected for the year or $2,550 (IRS may index annually) plus any Employer contributions that may be made, or in addition to any carryovers from a prior Plan Year, if applicable. (The $2,550 is inclusive of all Affiliated Employers in the same controlled group, and may be indexed each year to reflect any anticipated cost of living adjustments as assigned by the IRS.) In order to be reimbursed for a Healthcare Flexible Spending expense, you must submit your claim in the manner set forth under Section VI below. Reimbursement from the Plan will generally be paid no later than 30 days after receipt by the Administrator of a reimbursement claim.

**Dependent Care Assistance Account**

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent daycare costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time instead of being gainfully employed (but note the income limitations discussed below). Single employees can also use the account, subject to the applicable dollar limitations specified below.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements which qualify for expense reimbursement include:

a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable State and local laws.

b) An Educational Institution for pre-school children. For children beyond pre-school age, only expenses for non-school care (e.g., after-care) are eligible.

c) An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal income tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: 1) $5,000 (if you are married and filing a joint return, or single and head of a household) or $2,500 (if you are married, but filing separate returns); 2) your taxable compensation; 3) your spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of self-care has a monthly earned income of $250 for one dependent or $500 for two or more dependents), or such other amount as otherwise set forth and described under Section I, "General Information About Our Plan".

Also, in order to have reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan.

You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you. Even if you do not take the Federal tax credit you will still be required to complete Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses" with your annual tax return.

**Adoption Assistance Program**

The Adoption Assistance Program enables you to pay for out-of-pocket, qualifying adoption costs with pre-tax dollars, as well as possibly have all or a portion of amounts reimbursed under our Plan excluded from income, for tax purposes. The program allows you to be reimbursed by the Employer for reasonable and necessary adoption fees, courts costs, attorney fees, traveling expenses (including amounts spent for meals and lodging) while away from home, and other expenses directly related to the legal adoption of an eligible child (but not expenses that are in violation of State or Federal law, expenses incurred through a surrogate parenting arrangement, or expenses in connection with the adoption of a stepchild). It may also be a child within or outside of the United States, except to the extent it includes a child with special needs, as further described below.

An eligible child is a child who is under 18 years of age, or physically or mentally incapable of self-care, including a child with special needs. For these purposes, a "child with special needs" includes any child in which:

a) A State has determined that the child cannot or should not be returned to the home of his/her parents;

b) Such State has determined that there exists, with respect to the child, a specific factor or condition (such as his/her ethnic background, age, or membership in a minority or sibling

group; or the presence of factors such as handicaps), because of which, it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance; and

c) Such child is a citizen or resident of the United States (as defined in section 217(h)(3)).

The law places limits on the amount of money that can be paid to you in a calendar year from your Adoption Assistance Program. Generally, your reimbursements may not exceed a maximum amount as set forth under Code Section 137(b) (as adjusted for inflation, as otherwise set forth and described under Section I, "General Information About Our Plan") for each effort to adopt an eligible child. The amount and period within which you may claim reimbursement and/or exclusion from income can be different depending on whether it is the adoption of a child outside of the United States, a child with special needs, or other similar circumstances. You should contact the Administrator for more information about the options available to you and your situation.

In addition, Federal tax laws permit a tax credit for certain adoption expenses you may be paying for even if you are not a Participant in this Plan. You may take advantage of this tax credit and use the Adoption Assistance Program under our Plan if you have enough qualifying adoption expenses. However, certain income limitations under the Code may also limit your capability to utilize the credit or allow exclusion from income under our Plan. Please also note that even if you do not take the Federal tax credit, you may still be required to complete Federal Income Tax Form 8839, "Qualified Adoption Expenses," with your annual tax return. You should ask your tax adviser when to take the credit or the exclusion from income under our Plan, as well as whether your personal income situation is at a level that could limit the amount of benefit you might receive under this program and any other income reporting responsibilities you may have under these circumstances.

**Tax-Free Transportation Program:**

The Tax-Free Transportation Program enables you to pay for eligible transportation expenses costs with pre-tax dollars, as well as possibly have all or a portion of amounts reimbursed under our Plan excluded from income for tax purposes, as long as such amounts are not greater than the allowable monthly maximum amount, which is otherwise set forth and described under Section I, "General Information About Our Plan". The use of pre-tax dollars reduces your taxable income and you save Social Security and income taxes on the amount of your Salary Redirection. Eligible transportation expenses include:

a) **"Parking Expense,"** defined as expenses incurred to park your car on or near the business premises of your Employer or expenses incurred to park your car at a location from which you commute to work by 1) mass transit facilities, 2) a Commuter Highway Vehicle, or 3) carpool;

b) **"Transit Pass Expenses,"** defined as expenses incurred for a pass, token, fare card, voucher, or similar item (a "Pass") for transportation 1) on mass transit facilities, whether or not publicly owned, or 2) provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver);

c) **"Commuter Highway Vehicle (Vanpool) Expenses,"** defined as expenses incurred for transportation in a "commuter highway vehicle" if such transportation is in connection with travel between your residence and place of Employment. A Commuter Highway

Vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver), and for which at least 80 percent of the mileage is for purposes of transporting employees in connection with travel between their residences and their places of employment, and on trips during which the number of employees transported for such purposes is, on average, at least half of the adult seating capacity of the vehicle (not including the driver).

Unless other allowable payment processes are set forth to make payment or reimbursement for you or on your behalf in another manner under Section VI below, when you incur an expense that is eligible for payment, you must complete and submit a Request for Reimbursement Form (which will be supplied to you) to the Employer within 180 days of the date you incur the expense. Requests must be submitted for expenses incurred for an entire month; no partial-month requests will be considered for payment. As a general rule, you must submit a receipt (or other third party verification) along with your claim form.

If your reimbursement request was for less than your current Tax-Free Transportation Program Account balance, the unused amounts in your Account will be available for future reimbursements. You may need to adjust the election for the next coverage period in order to use up your surplus Account balance.

For example, if your monthly parking election (and anticipated monthly expense) is $100, but you only incur $75 worth of eligible parking expenses in January, you might want to change your election for February to $75 in order to use up the $25 surplus from January. Then you can increase your election to $100 for March prior to March 1.

If your reimbursement request was for an amount that was less than the monthly maximum amount (as otherwise set forth and described under Section I, “General Information About Our Plan”), but more than your current Tax-Free Transportation Program Account balance, the excess part of the reimbursement will be carried over into following months to be paid out as your balance becomes adequate (subject to the monthly maximum). You may not be reimbursed for any expenses that arise before your Salary Redirection agreement becomes effective.

If you are provided a transit pass that is purchased directly by the Employer, or if other electronic payment processes are allowable under your Plan in accordance with Section VI below, your Account will be debited directly for the cost of the transit pass. You will not need to submit a request for reimbursement form.

In addition, you will have 30 days after the end of the Plan Year in which to submit a Request for Reimbursement Form for eligible transportation expenses incurred during the previous Plan Year. You will be notified in writing if any request for reimbursement is denied.

If you have any funds in your Account at the time you terminate employment, any amounts not applied for eligible transportation expenses incurred prior to the termination and unclaimed within 30 days of your termination of employment will be forfeited.

**Health Savings Account (HSA)**

In addition to the Healthcare Flexible Spending Account, this Plan also may provide for the payment of other qualifying medical expenses not paid for through an insurance plan through the use of a “Health Savings Account (HSA).” This type of program is intended to enable eligible individuals who elect to participate in this program to submit claims for the reimbursement of eligible HSA medical expenses or

allow distribution of remaining balances for other qualifying purposes (although income taxation may result if distributions are made for non-medical expense reimbursements as discussed below).

In general, unless otherwise excluded from participation under this program under Section I above, all Participants under the Flexible Benefits Plan are eligible to receive Benefits under this HSA Program, as long as they otherwise meet the definition of an "Eligible Individual" as defined below. The enrollment and termination of participation under the Flexible Benefits Plan shall constitute enrollment and termination of participation under this HSA Program. In addition, other matters concerning contributions, elections, and the like shall be governed by the general provisions of the Flexible Benefits Plan.

For HSA purposes, you are an "Eligible Individual" who may participate in the HSA if you or your covered Dependents are:

a) Covered under a qualifying High-Deductible Health Plan (that is provided through your Employer);

b) Not an individual that may be claimed as a dependent by another person for tax purposes, under Code Section 151; and

c) Not covered under any other health plan (other than stand-alone dental, vision, accidental death and dismemberment, long-term care, or other similar type of policy or program of coverage, including insurance for a specified disease or illness).

Please note, however, that you will no longer be considered as an "Eligible Individual" that is entitled to receive additional contributions of Flexible Benefits Plan Dollars to any HSA under this Plan when you become enrolled in Medicare benefits under Title XVII of the Social Security Act. Subject to applicable filing deadlines, you would, however, be entitled to still utilize the balance of any remaining amounts that remain within your HSA at the time of Medicare enrollment.

Once eligible and elected, the Administrator will establish a Health Savings Account for each person who elects to apply Flexible Benefits Plan Dollars, receive IRA rollovers, as applicable, to HSA Program benefits (subject to annual contribution limits set forth above and in accordance with applicable Code requirements; contributions made in excess of allowable annual limits would be subject to applicable excess contribution penalties). If elected under your Employer's Adoption Agreement (and as identified under Section I, "General Information About Our Plan"), you may be eligible to submit expenses under your HSA during any existing Claim Extension Period, as long as your Healthcare Flexible Spending Account is deemed to have a "zero balance account" as of the end of the last Plan Year. You should also note that certain contributions to the HSA may be subject to additional income and excise taxes if applicable Testing Periods established under Code Section 223 are not satisfied. You should contact the Administrator regarding the impact of any of these special rules or any applicable tax ramifications that may result under your situation.

Under this program, as an Eligible Individual that is enrolled in the HSA, you and your dependents are entitled to receive reimbursement under the HSA for qualifying medical expenses that, unless otherwise provided for under this Plan (as identified under Section I above), are for the cost of medical care (as defined under Code Section 213(d)), but only to the extent not compensated by or paid for by insurance (or unless it is for the purchase of coverage that is allowable under Code Section 223(d), which includes among other costs, COBRA, long-term care insurance, unemployment coverage, Medicare, etc.). You

should make sure that the medical expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Health Savings Account. For example, you cannot be reimbursed for expenses incurred before you became eligible under the Plan, nor can you be reimbursed for amounts that exceed the balance that remains in your account.

If all other criteria have been established, all HSA claims incurred by you or your qualifying dependents shall be reimbursed during the Plan Year, even though the submission of such a claim may occur after your eligibility participation hereunder ceases, provided that the HSA expenses were incurred during the applicable Plan Year and after you became eligible under this Plan. Claims shall generally be payable in accordance with the Benefit Payments provisions described under Section VI below.

You may also request distribution of all or a portion of your existing HSA balance for any other reason. Such amounts will be paid to you, your dependents or other qualifying beneficiary(ies) as soon as administratively feasible. However, to the extent such distributions are for other than actual reimbursement of qualifying HSA expenses, the amount distributed will be subject to income tax and a 20 percent excise tax penalty. Exceptions may exist in circumstances where the distribution is being made pursuant to an employee's death or disability. You should contact the HSA Trustee or Custodian for additional information on allowable distributions made at or subsequent to an employee's death or disability.

Your Health Savings Account will be increased each pay period by the portion of Flexible Benefits Plan Dollars that you elect to apply toward your HSA, as well as can be increased by any rollover amounts that are accepted by this Plan from another qualifying HSA, allowable Individual Retirement Accounts, and due to any periodic interest income or other investment earnings accumulations that your Employer elects to apply towards your HSA balance. Your Employer also has the ability to make pre-tax contributions to your HSA account on your behalf, although remaining subject to the same annual contribution limitation set forth above, as well as must adhere to existing nondiscrimination requirements as applicable. Correspondingly, your HSA balance will be reduced by the amount of any qualifying HSA medical expenses reimbursements paid by the HSA Trustee or Custodian on behalf of you or your qualifying dependents. Your HSA balance will also be reduced for any other distributions made in accordance with the terms of the Plan, any applicable rollovers to any other HSA plan and, if elected by your Employer, for any depreciation in interest earnings or other investment accumulations that have resulted during the Plan Year.

By the deadline set forth in accordance with your Plan, the Administrator will provide you with at least an annual statement of all contributions made to the HSA as well as such benefits or other distributions paid to or on your or your dependent(s) behalf during the prior calendar year. The amount in any remaining HSA balance as of the end of any Plan Year (and after the processing of all claims for such Plan Year) will be carried over and available for use in the subsequent Plan Year (in addition to any further contribution amounts or other Flexible Benefits Plan Dollar contributions made during the next Plan Year(s)).

If your Employer offers the Healthcare Flexible Spending Account Program under this Plan in addition to this HSA, to the extent you elect to participate in the HSA and the Healthcare Flexible Spending Account Program, any qualifying medical expense amounts that can be paid under the HSA Program of this Plan may be paid by the HSA (through submission of those claim reimbursement requests to the HSA Trustee or HSA Custodian) with the exception of "limited benefits" (i.e., vision and dental

benefits) that may be paid concurrently from the Healthcare Flexible Spending Program through submission of claim requests to the Administrator.

# VI

# BENEFIT PAYMENTS

## 1. How do I request reimbursements from my account?

During the course of the Plan Year, you may submit requests for reimbursement of expenses that you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when they are paid for. The Administrator will provide you with forms, or other online claim processing instructions, for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement, which is payment, soon thereafter. Remember, reimbursements that are made from the Plan are generally not subject to Federal income tax or withholding. Nor are they subject to Social Security taxes. Also note that you must submit all requests for reimbursement of any health care, dependent care, or adoption expenses no later than 90 days after the end of the Plan Year, or as of a later date if your Employer has adopted a Claims Extension Period, as otherwise described under Section IX below. Requests for payment of insured benefits should be made directly to the Insurer. The provisions of the insurance policies will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Assistance Plan, Adoption Assistance Program, Tax-Free Transportation Program, or Health Savings Accounts to the extent that there are sufficient funds in the applicable accounts to cover your request.

## 2. How are benefits paid to me?

a) The Administrator will make any and all payments or other reimbursements to you as soon as administratively feasible or as otherwise set forth herein and will be distributed in the manner elected by your Employer (including direct reimbursement by check, automatic deposit via automated clearing house (ACH)).

b) As an alternative to the method of Benefit payment referenced above, if you agree to the terms and conditions of any applicable cardholder agreement (that is also agreed to by your Employer and the Administrator, with any additional provisions or requirements) that provides for the payment of qualifying Benefit expenses through use of a debit or credit card, stored value card or other similar electronic media (generally referred to as the "Debit Card"), payment of qualifying Benefit expenses may be made directly to the service provider, authorized merchant, or other independent third party using claim substantiation procedures and policies in accordance with existing IRS guidelines and other applicable laws set forth below:

c) If the Benefit reimbursement request is being submitted for any nonqualifying Benefit expense in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator will make a conditional payment of an allowable Benefit item to the authorized service provider, merchant, or approved

independent third party, but will also require you to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which will be subject to further review and substantiation;

d) If any conditional payment or other Benefit payment has been made but is not deemed to be a qualifying expense reimbursement, the Administrator will ensure that proper correction procedures are maintained with respect to the improper payment(s):

(1) Upon identification of any improper payment, the Administrator will require you to pay back to the Plan an amount equal to the improper payment;

(2) If you do not immediately repay the Plan, the Administrator will ensure that the proper amount is withheld from your wages or other compensation (with such amounts then being immediately remitted to the Plan by your Employer) to the extent consistent with applicable law;

(3) To the extent that neither (1) or (2) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to you as part of your cardholder agreement;

(4) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by you. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or your cardholder agreement.

Under all circumstances, you must agree that payment for qualifying Benefit expenses can only be made on behalf of you, your spouse, or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth herein.

By signing the cardholder agreement, you are also certifying that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. You are also certifying that you understand this agreement is reaffirmed each time the card is used. You will further agree to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate. Lastly, in signing the cardholder agreement, you certify that you understand that the Debit Card is automatically cancelled at termination of employment or under such other situations that are otherwise set forth within the cardholder agreement itself.

If you attempt to utilize the debit card or other form of electronic payment for any improper or non-allowable purpose, you will be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by you.

## 3. What happens if I terminate employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

b) You will still be able to request reimbursement for qualifying dependent care expenses for a period following the date of termination from the balance remaining in your Dependent Care Assistance Account at the time of termination of employment, provided the expenses are submitted in accordance with Section 15 of this Summary. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate.

c) Under the Health Savings Account, you may submit qualifying expenses for reimbursement under the Plan that were incurred prior to your date of termination, request distribution of any remaining HSA balance amounts, or roll over any unused HSA balance to another qualifying HSA established on your own or through another employer. You may contact the HSA Trustee or Custodian for more information as to how to transfer any such amounts under these circumstances.

d) You may elect to continue your participation in the Healthcare Flexible Spending Account for the remainder of the Plan Year subject to current COBRA provisions (including applicable provisions that may reduce or eliminate your ability to maintain COBRA eligibility). Please refer to the initial COBRA notification in Attachment A for additional information. The Plan Administrator will notify you as to your COBRA eligibility (if any) at the time of your qualifying event.

    1) If you elect to continue your participation in the Healthcare Flexible Spending Account, you must continue to make any required contributions to the Plan at the same level you had prior to your termination. Depending on the elections made by your Employer, you may be able to continue making such contributions on a pre-tax basis if you continue to receive compensation after your termination from employment. Otherwise, your contributions would be required on an after-tax basis only.

    2) If you elect not to continue participation in the Healthcare Flexible Spending Account, participation will cease and no further salary redirection and Employer contributions will be made on your behalf.

    3) If your participation in the Healthcare Flexible Spending Account ceases, you will be able to submit claims for healthcare expenses incurred prior to your date of termination for a period following your termination date provided the expenses are submitted in accordance with Section 15 of this Summary.

## 4. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced. That is because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

# VII

# HIGHLY COMPENSATED AND KEY EMPLOYEES

## 1. Do limitations apply to Highly Compensated Employees?

Under the Internal Revenue Code, "Highly Compensated Employees" and "Key Employees" generally are Participants who are officers, shareholders, or highly paid employees. You will be notified by the Administrator each Plan Year whether you are a "Highly Compensated Employee" or a "Key Employee."

If you are within these categories, the amount of contributions and benefits paid for you under this Plan may be limited so that the Plan, as a whole, does not unfairly favor those who are highly paid, their spouses, or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the Key Employees if they, as a group, receive more than 25 percent of all of the nontaxable benefits provided for under our Plan.

Your own circumstances will dictate whether contribution limitations on "Highly Compensated Employees" or "Key Employees" will apply. You will be notified of these limitations if you are affected.

# VIII

# PLAN ACCOUNTING

The Administrator will make available to you a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember that you want to spend all of the money you have designated for a particular benefit by the end of the Plan Year.

# IX

# ADDITIONAL PLAN INFORMATION

## 1. Your rights under ERISA

Plan participants, eligible employees, and all other employees of the Employer are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that participants, eligible employees, and all other employees are entitled to:

a) Examine, without charge, at the Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and

b) Obtain copies of all Plan documents and other Plan information upon request to the Administrator. The Administrator may charge a reasonable fee for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other plan participants.

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 (or such greater amount as determined by the U.S. Department of Labor) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

## 2. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

a) The reasons for the denial;

b) Reference to the specific provisions of the Plan on which the denial was based;

c) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;

d) A description of the Plan's review procedures and time limits applicable to such procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;

e) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

f) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request.

You or your beneficiary will have 180 days following the receipt of any notification of claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records, or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge.

The Administrator will review the claim, without deference to the initial denial and after taking into account all comments, information, documents, records, and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 120 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

## 3. CLAIMS INCURRED DURING THE "CLAIMS EXTENSION PERIOD"

The provisions of the Plan concerning the payment of qualifying expenses or other similar benefits, which may include, but is not limited to payment from, health care reimbursement accounts, dependent care assistance accounts or other similar arrangements, that would otherwise be forfeited if not incurred by the end of the Plan Year. The provision for the "Claims Extension Period" under the Plan is

identified under Section I, "General Information About Our Plan'. Please refer to "General Information About Our Plan" to determine if this provision applies to your Plan.

1. Claims Incurred Prior to the End of the Plan Year. For purposes of any provisions within the Plan that require qualifying expenses or other similar benefits to have been incurred by the end of the Plan Year to be eligible for reimbursement by the Plan, as of the Effective Date of this amendment, the Plan shall also reimburse any qualifying expenses or other similar benefits that are incurred within the Claims Extension Period immediately following the end of the Plan Year with amounts remaining in the participant's applicable Healthcare Flexible Account reimbursement, unless the Plan allows carryovers from a prior Plan Year, Dependent Care Assistance, Adoption Assistance, or other similar Plan account as of the end of the Plan Year. Any Plan provisions related to the deadline for forfeiture of any unused Plan accounts that are not utilized by the end of the Plan Year shall also take into consideration the Claims Extension Period.

2. Claims Extension Period—Defined. For purposes of these rules, the "Claims Extension Period" shall be the period that ends on the 15th day of the third month immediately following the end of the most recent Plan Year. For example, if your Plan Year ends on December 31st, you have until March 15th of the following Plan Year to incur qualifying expenses and until March 31st, to submit qualifying expenses for reimbursement.

3. Order of Expense or Benefit Payment. Amounts remaining in the participant's applicable Healthcare Flexible Account reimbursement, unless the Plan allows carryovers from a prior Plan Year, Dependent Care Assistance, Adoption Assistance, or other similar Plan account as of the end of the Plan Year shall be used first for the payment of any claims submitted during the Claims Extension Period. If all prior year amounts have been fully utilized, claims incurred during the Claims Extension Period shall be paid from any amounts elected for the Plan Year immediately coinciding with the Claims Extension Period. For these purposes, amounts remaining in one Plan account cannot be used to supplement the lack of available funds from another Plan account (e.g., excess amounts within a participant's Dependent Care Assistance account may not be used to fund Healthcare Flexible Spending account claims incurred during the Claims Extension Period).

4. Forfeitures. Any amount(s) that remain as of the end of any Plan Year (including the processing of all allowable claims submitted during the Claims Extension Period, pursuant to Section 1 above) shall be forfeited and credited to any benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to any claims appeal rights otherwise set forth herein.

5. Claims Submission Deadline. All claims reimbursement requests must be submitted by the end of the month following the end of the Claim Extension Period deadline. For example, if your Plan Year ends on December 31st, and your Claims Extension Period ends on March 15th, you have until March 31st to submit claims incurred during the previous Plan Year and the Claims Extension Period.

## 4. HIPAA Privacy

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 ("HIPAA"), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to Participants in those plans. HIPAA applies to the Plan Year of this Plan.

Protected Health Information or "PHI" is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment.

The Plan may disclose PHI to the Employer only for limited purposes as described in the Plan's documents. The Employer agrees to use and disclose PHI only as permitted or required by the Plan's documents or as required by HIPAA. PHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of Eligible Employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

In order to perform these functions, the Plan will use and disclose PHI only to the following individuals:

- Plan Administrator
- HIPAA Privacy Official
- Other Personnel, specifically designated by the Plan's Privacy Official

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI, as well as the use and safeguarding of electronic PHI that is otherwise subject to applicable HIPAA Security guidelines as well. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance. A notice has been provided to you summarizing the Plan's policies and procedures. A copy of this notice is also attached as Attachment B.

## X

## SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. Our Flexible Benefits Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator listed under Section I, "General Information About Our Plan."

# Attachment A

# **CONTINUATION COVERAGE RIGHTS UNDER COBRA**

## Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

## What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

## When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event.

You may elect to continue participation in the Plan in accordance with proposed IRS Regulations. However, unless the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") applies to your Plan, the continuation coverage will be offered until the end of the Plan Year in which the qualifying event occurs. COBRA continuation coverage generally will not be offered to Healthcare Flexible Spending Account Participants under the following circumstances:

a) The Healthcare Reimbursement Account has a deficit at the time of the qualifying event. If, taking into account all claims submitted on or before the date of the qualifying event, your remaining Healthcare Flexible Spending Account balance for the Plan Year is less than the maximum required COBRA Premiums for the rest of the year.

b) COBRA continuation will not be offered to a Healthcare Flexible Spending Account Participant in any Plan Year following the Plan Year in which the qualifying event occurs if:

   1) The Healthcare Flexible Spending Account is Exempt from HIPAA. The Healthcare Flexible Spending Account is exempt from HIPAA if a major medical plan is available in addition to the Healthcare Flexible Spending Account, and the Healthcare Flexible Spending Account benefit does not exceed two times the salary redirection or, if greater, the salary redirection plus $500; and

2) For the Plan Year in which the qualifying event occurs, the maximum amount you could be required to pay for a full year of Healthcare Flexible Spending Account COBRA coverage equals or exceeds the maximum benefit available to you for the Plan Year.

However, your Employer may choose to offer COBRA continuation coverage, notwithstanding the exceptions detailed above. If your Employer chooses to provide such additional COBRA continuation coverage, you will be provided with additional information about any other rights you may also have at that time.

## You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Please refer to Section I, "General Information About Our Plan" of this document for your Plan Administrator's name and address

## How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage.** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage

and must last at least until the end of the 18-month period of continuation coverage. You must provide written notice of any such disability, along with copies of any such written determination received from the Social Security Administration and the date it was received, to: [Name of the appropriate party to whom notice must be sent]. This information must be received by the applicable Plan representatives no less than 30 days before the end of the 18-month continuation coverage period.

**Second qualifying event extension of 18-month period of continuation coverage.** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

## Keep your Plan Administrator informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Plan contact information

For more information about the Plan and your rights thereunder, contact the Plan Administrator listed under Section I, "General Information About Our Plan."

# Attachment B

# **HIPAA NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## Purpose

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.
As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

## Uses and Disclosures of Health Information

**Healthcare Operations.** We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

**Payment.** We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

**Treatment.** Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

**As permitted or required by law.** We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

**Pursuant to your Authorization.** When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

**Right to Inspect and Copy.** In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

**Right to an Accounting of Disclosures.** You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

**Right to Amend.** If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

**Right to Request Restrictions.** You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

**Right to Request Confidential Communications.** You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

**Right to Receive a Paper Copy of this Notice.** If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

## Legal Requirements

We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice. We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.
If you have any questions or complaints, please contact the Plan Administrator listed under Section I, "General Information About Our Plan."

## Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit *www.hhs.gov/ocr* for further information.

# MEMPHIS-SHELBY COUNTY AIRPORT AUTHORITY
## SECTION 125 FLEXIBLE BENEFITS PLAN

# AMENDMENT
# EFFECTIVE JANUARY 1ST, 2020

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Fed Tax ID: 62-1262331 Plan Code: 501 Section 125 Cafeteria Plan

This is an amendment of the following section of the Adoption Agreement for this Section 125 Plan.

The undersigned, being the authorizing officer(s) of the Memphis-Shelby County Airport Authority Section 125 Flexible Benefit Plan, do hereby consent to the following amendment to the previous Adoption Agreement:

## ADOPTION AGREEMENT

**10. Contributions:**

The contributions for this Plan shall be:

- ☑ Employee (Salary Redirection) contributions, and
- ☑ Employer Contributions of $200 each Plan Year.

The effective date of this amendment shall be January 1st, 2020.

**IN WITNESS WHEREOF**, the Employer has caused this Amendment to the Plan Document Adoption Agreement to be executed this _____ day of _____, 20_____.

**MEMPHIS-SHELBY COUNTY AIRPORT AUTHORITY**

By: _____

Title: _____

# MEMPHIS-SHELBY COUNTY AIRPORT AUTHORITY
## SECTION 125 FLEXIBLE BENEFITS PLAN

## SUMMARY PLAN DESCRIPTION
AMENDMENT EFFECTIVE JANUARY 1ST, 2020

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Section 125 Flexible Benefits Plan Plan Number: 501

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This is an amendment of the following section of the Summary Plan Description for this Section 125 Flexible Benefits Plan.

The authorizing officer(s) of the Memphis-Shelby County Airport Authority Section 125 Flexible Benefits Plan have consented to the following amendment to the Section 125 Plan Summary Plan Description.

## I
## CONTRIBUTION ELECTIONS

**12. Contributions:**

The contributions for this Plan shall be:

- ☑ Employee (Salary Redirection) contributions, and
- ☑ Employer Contributions of $200 each Plan Year.

***Attach this Amendment to your copy of the Summary Plan Description***

September 25th, 2019

Mr. Nathan Luce, P.E.
Memphis-Shelby County Airport Authority

Re: Section 125 Flexible Benefit Plan - Amendment Effective 01-01-20

Amendment to Section 125 Plan Documents
Adoption Agreement (1)
Summary Plan Description (1) $ 50.00
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Total amount added to your monthly statement..... $ 0.00 Waived per A. Lane

This amendment was prepared to add the Employer Contribution for employees in this benefit plan.

## STEPS FOR IMPLEMENTING AMENDMENT

Amendment Package Contents:

1. Amendment to the Adoption Agreement
2. Amendment to the Summary Plan Description (SPD)
3 Invoice and Instructions

The following steps should be taken:

_____ (1) Authorizing officer signs the Amendment to the Adoption Agreement.

_____ (2) The new signed Amendment is attached to the Master Plan Document

_____ (3) A copy of the SPD Amendment page is to be attached to the Master SPD.

_____ (4) Distribute the SPD Amendment page to each participant.

_____ (5) Email a copy of the signed Amendment to CPN to complete our files.

*P. O. BOX 1748 / CORDOVA, TN 38088*
*www.cpnflex.com*

# Memphis-Shelby County Airport Authority- FSA Debit Card - FACT SHEET

**Plan Year:** January to December

**FSA funds are for services incurred during the "current – active" plan year only.**
(For example: An FSA plan year 1.1.2024 to 12.31.2024 can only be used for services incurred from 1.1.2024 to 12.31.2024; meaning you CANNOT claim a service rendered in November of 2023. This would result in the service being rejected and repayment requested by the employee because the service was not rendered between 1.1.2024 to 12.31.2024.)

**CPNFLEX FSA debit card is used for the below:**

- Card is used for medical, dental, vision, prescriptions and "qualified" OTC items.
- Itemized statement showing service date and services rendered will be required for medical & dental charges (excluding co-pays; if applicable).
- Cash Register receipts are **NOT ACCEPTABLE**.

*****CARD SUSPENSION NOTICE***** If any charge(s) on a participants account are not substantiated in a timely manner, their CPNFLEX card is subject of being temporarily suspended until the charge(s) have been addressed. Participants are sent follow-up notices to the email address on file with CPN. It is recommended to have the participant log onto their personal ***Consumer Portal*** where they can view the charge(s) in question and upload the necessary documentation from there as well.

**NOTE:** Dependent Care Spending Account is accessible through manual claims only and is **NOT** linked to the CPNFLEX debit card.

**Health FSA Carryover:**
Up to $500.00, unused funds on the 2023 Health FSA will carry over to the next plan year (2024), to be used for the next plan years' (2024), service dates. Carryover funds are generated approximately six (6) days after prior plan year ends to allow any "in-process" debit card charges to settle on prior plan year account.

**FSA RUN-OFF PERIODS:**

- **Run-off period to file claims after plan year ends: 90 days**
  (Previous Plan Year Services must be filed using the manual reimbursement submittal process; you CANNOT use your CPNFLEX debit card to pay for prior year services during the run-off period. As of 1.1.2024, the CPNFLEX card can only be used for services incurred in 2024 plan year.)

- **Run-off period to file claims after termination date: 45 days**
  (Services must be incurred during dates of eligibility or the claim will be denied)

**OTHER HELPFUL FACTS:**

- **CPNFLEX Debit Card Activation Number:** 866.898.9795

- **CPN's Customer Service Center Contact Info.** – Phone: 901.756.8244, Press 1 / Toll Free: 800.737.0125 / Email: claims@cpnflex.com – Monday thru Friday, 8am to 4pm, CDT)

- **Dispute a CPNFLEX debit card charge** – Employees may download the Dispute Card Form & Process from their Consumer Portal / click on Tools & Support

- **Report CPNFLEX debit card Lost/Stolen** – Employees may do this from their Consumer Portal / click on Tools & Support or by emailing customer service at claims@cpnflex.com Email Subject Line: Report Card Lost/Stolen. This may also be done from the CPNFLEX mobile app by going to: Profile / MANAGE DEBIT CARDS

- **Consumer Portal Information**: Handout materials for setting up the employee's Consumer Portal, adding/requesting a debit card for a dependent and even how to substantiate CPNFLEX debit card charges, can be found on CPN's website – www.cpnflex.com located under the **Consumer Info** page.