State of Delaware Cafeteria Benefits Plan

Amended and Restated Effective January 1, 2024

Original Effective Date: January 1, 2002

State of Delaware Cafeteria Benefits Plan

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Section 1 Introduction

1.1 Establishment of the Plan

State of Delaware (the "Employer") hereby amends and restates the State of Delaware Cafeteria Benefits Plan (the "Plan"), a Cafeteria Plan, effective January 1, 2024. The original Effective Date of the Cafeteria Plan is March 1, 2002 (the "Effective Date"). The State of Delaware Cafeteria Benefits Plan was originally established January 1, 1989. The Plan was established to provide Eligible Employees (as determined by the Plan) or the Employer the opportunity to choose among cash and health benefits (including state medical, prescription drug, dental, vision, accident and critical illness; local district dental and vision benefits), reimbursement under a Health Care Flexible Spending Account, and reimbursement under a Dependent Care Flexible Spending Account.

The Plan Sponsor intends to continue this Plan indefinitely; however, the Plan Sponsor at any time and from time to time may amend, change, or terminate the Plan in writing, without the consent of any person(s) entitled to receive payment of Benefits under the Plan.

1.2 Purpose of the Plan

This Plan allows an eligible employee ("Eligible Employee") to participate in the following Benefit Options:

- **Health Benefits** to make pre-tax Salary Reduction Contributions to pay for certain state medical, dental, vision and prescription drug expenses (including local district dental and vision benefits).

- **Accident and Critical Illness Benefits,** which provide protection in the event of certain accidents or illnesses.

- **Health Care Flexible Spending Account (HCFSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.

- **Dependent Care Flexible Spending Account (DCFSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.

1.3 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code (IRC) Section 125, and regulations issued thereunder and shall be interpreted to accomplish that objective. The Health Care Flexible Spending Account under the Plan is intended to qualify as a "self-insured medical reimbursement plan" under Code Section 105, and the Qualified Medical Expenses reimbursed under that Program are intended to be eligible for the exclusion from Participants' gross income under Code Section 105(b).

The **DCFSA** is intended to qualify as a Dependent Care Flexible Spending Account under Code Section 129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a).

The **HCFSA** is also a separate plan for purposes of applicable provisions of COBRA and HIPAA. The Dependent Care FSA Program is a separate plan for purposes of administration and non-discrimination requirements imposed by Code Section 129. As this Plan is a governmental plan, it is not subject to ERISA.

1.4 Capitalized Terms

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in Section 2 (Glossary) or in other relevant Sections. When reading the provisions of the Plan, please refer to Section 2 (Glossary).

Becoming familiar with the defined terms will provide a better understanding of the procedures and Benefits described.

Section 2 Glossary

Capitalized terms used in the Plan have the following meanings:

Accident Insurance means Accident benefits sponsored by the Employer.

Benefit or Benefits means the Benefit Options offered under the Plan.

Benefit Option means a qualified benefit under Code Section 125(f) that is offered under this Cafeteria Plan, or an option for coverage under the accident or critical illness plan.

Cafeteria Plan means the State of Delaware Cafeteria Benefits Plan as set forth herein and as amended from time to time.

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

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

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to: any Salary Reduction election under this Plan; any Salary Reduction election under any other cafeteria plan; any compensation reduction under any Code Section132(f)(4) plan; and any salary deferral elections under any Code Sections 401(k), 408(k) or 457(b) Plan or arrangement.

Component Benefit Plan(s) means any one of the plans supporting the Optional Benefits described in Plan Section 3.1.

Contribution means the amount contributed to pay for the cost of Benefits as calculated under the Benefit Options.

Critical Illness Insurance means Critical Illness benefits sponsored by the Employer.

DCFSA means Dependent Care Flexible Spending Account**.**

Dental Plan means the dental benefit plan sponsored by the Employer.

Dependent means any individual who is a tax dependent of the Participant as defined in Code Sections 105(b) and 152, with the following exceptions:

- For purposes of accident or health coverage (for purposes of the **HCFSA**):
    - A Dependent is defined as in Code Sections 105(b) and 152, determined without regard to Section 152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and

o Any child whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year) is treated as a Dependent of both parents; and

- For purposes of the **DCFSA**, a Dependent means a Qualifying Individual.

The inclusion of Code Section 105(b) in the definition of "Dependent" will allow for reimbursement of expenses for adult children until the end of the month in which the child attains age 26.

Notwithstanding the foregoing, the **HCFSA** Component will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent Care Flexible Spending Account means the Dependent Care Flexible Spending Account component established by Employer under the Plan. It allows the Participant to use pre-tax dollars to pay for the care of the Participant's eligible Dependents while the Participant is at work.

Dependent Care Expenses has the meaning described in the **DCFSA** Schedule B that is included in this Plan.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation Benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include: any amounts received pursuant to any **DCFSA** established under Code Section 129; or any other amounts excluded from Earned Income under Code Section 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

Effective Date of this Plan shall be July 1, 2020. The plan is amended and restated effective January 1, 2024.

Eligible Employee means any Employee who meets the eligibility requirements set forth in the State of Delaware Cafeteria Benefits Plan.

An Employee shall not be eligible to be a Participant, however, while the Employee is a member of a classification of Employees that the Employer designates as not currently eligible to be Participants. The Employer may at any time and from time to time remove any one or more Employees or any other group(s) or class(es) of Employees from eligibility for participation in this Plan, provided that in no event shall any such removal decrease or dissipate amounts theretofore redirected from a Participant's Compensation, such amounts in all events to be used for the exclusive benefit of the Participant under the Component Benefit Plans.

Employee means an individual who is benefit eligible as defined by the Plan;

The following classes of employees cannot participate in the State of Delaware Cafeteria Benefits Plan:

- Leased employees (as defined by Code Section 414(n));

- Contract workers and independent contractors;
- Temporary employees, casual employees, and employees hired short-term to meet specific needs of the Employer whether or not such persons are on the Employer's W-2 payroll;
- Individuals paid by a temporary or other employment or staffing agency;
- Self-employed individuals; and
- Any more than 2% shareholders of S corporations.

Employer means State of Delaware.

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

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

Health Benefits means medical, prescription drug, dental and vision benefits.

Health Care Expenses has the meaning defined in the **HCFSA** Schedule A.

Health Care Flexible Spending Account means the Health Care Flexible Spending Account component established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for most health and dental expenses not reimbursed under other programs.

HCFSA means Health Care Flexible Spending Account.

Health Plan means the health benefit plan sponsored by the Employer.

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

Non-health benefits include the DCFSA.

Open Enrollment Period with respect to a Plan Year means a period as described by the Plan Administrator preceding the Plan Year during which Participants may make Benefit elections for the Plan Year.

Optional Benefit means the benefit plan option elected by a Participant with respect to the Component Benefit Plans as described in Section 3 (Benefit Options and Method of Funding).

Participant means a person who is an Employee and who is participating in this Plan in accordance with the provisions of Section 4 (Eligibility and Participation). Participants include: (a) those that elect to receive Benefits under this Plan and enroll for Salary Reductions to pay for such Benefits; and (b) those that elect instead to receive their full salary in cash and have not elected the **Healthcare FSA or Dependent Care FSA**.

Period of Coverage means the Plan Year, with the following exceptions: for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 4 (Eligibility and Participation); and for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 4 (Eligibility and Participation).

PHI means Protected Health Information as defined herein.

Plan means the State of Delaware Cafeteria Benefits Plan, as set forth herein and as amended from time to time.

Plan Administrator means State of Delaware.

Plan Year means the twelve-month period ending June 30.

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

QMCSO means a Qualified Medical Child Support Order.

Qualifying Dependent Care Services has the meaning described in the **DCFSA** Schedule B.

Qualifying Individual means:

- A tax dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1);

- A tax dependent of the Participant as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- A Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code Section 21(e)(5), shall be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

Related Employer means any employer affiliated with State of Delaware that, under Code Section 414(b), (c), or (m), is treated as a single employer with State of Delaware for purposes of Code Section 125(g)(4), and which is listed in Appendix B.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefit Options.

Salary Reduction Agreement means the agreement, form(s) or Internet web site, which Employees use to elect one or more Benefit Options. The agreement and/or forms spell out the procedures used for allowing an Employee to participate in this Plan and will allow the Employee to elect Salary Reductions to pay for any Benefit Options offered under this Plan.

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

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

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Vision Plan means the vision benefit plan sponsored by the Employer.

Section 3 Benefit Options and Method of Funding

3.1 Benefits Offered

Each Participant may choose under this Plan to receive their full Compensation for any Plan Year in cash or to have a portion of their Compensation applied by the Employer toward the cost of Benefit coverage under the following benefit plan options as communicated annually in writing by the Plan Administrator.

- **Premium Payment Program.** The Employer sponsors a Health Plan that offers certain Optional Benefits (e.g., state medical care, prescription drug, dental, vision, accident and critical illness coverage; includes local district dental and vision benefits) to provide Benefits to Employees and their dependents. The types and amounts of such Benefits, the Coverage Options available, the requirements for participation, and the terms and conditions of coverage and the payments for Benefits are set forth in the benefit booklets, including any commercial insurance contract(s), contract(s) with health maintenance organizations, or contract(s) with third party organizations in effect from time to time under the programs. Benefits are provided by the Component Benefit Plans described in the benefit booklets, and not this document. The premiums for the Health Plan are payable on a pre-tax basis under the Premium Payment Program of this Plan.

  Notwithstanding any provision to the contrary in this document, to the extent required by COBRA, the Health Plan is intended to comply with the continuation coverage provisions of COBRA. Contributions for COBRA coverage for Health Plan Benefits may be paid on a pre-tax basis by current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either because (a) the Employee ceases to be eligible because of reduction in hours or (b) the Employee's dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment or layoff), Contributions for COBRA for applicable Health Plan Benefits shall be paid on an after-tax basis (unless otherwise permitted by the Plan Administrator on a uniform and consistent basis), but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

- **Health Care Flexible Spending Account (HCFSA)** as described in Schedule A.

- **Dependent Care Flexible Spending Account (DCFSA)** as described in Schedule B.

- **Employer Paid Benefits.** The Employer may sponsor other Benefit plans that are paid for by the Employer and do not require Employee Contributions. These coverage offerings may vary by business units within the Employer's controlled group, as defined under Code Section 414(b). These coverages are described in the benefit booklets provided to Employees.

Notwithstanding anything in this document to the contrary, a Participant's right to make elections under this Plan shall not be deemed or construed in any manner whatsoever as entitling an Employee to participate in any underlying employee Benefit Plan of the Employer when the Employee meets the eligibility and participation requirements thereof. While the election to receive the Optional Benefits described above may be made under this Plan, the Benefits will not be provided by the terms of this Plan but by the terms of the

Component Benefits Plan. This Plan is intended to be merely a payment mechanism for the Employee's share of the cost of the Optional Benefits described above.

Benefits under the Plan shall not be provided in the form of deferred Compensation. An Eligible Employee will include any individual who is eligible for at least one of the Component Benefit Plans. A former Employee may continue eligibility for the remainder of the Plan Year in which the Employee ceased to be employed by the Employer, as required by any applicable law with respect to any Optional Benefit. The Component Benefit Plans incorporated in this Plan may have their own eligibility requirements for participation. The eligibility rules of such Component Benefit Plans are in addition to the eligibility rules of this Plan.

3.2 Determination of Eligibility by the Plan Administrator

The determination of an Employee's eligibility to participate in this Plan shall be made by the Plan Administrator, and the Plan Administrator's good faith determination shall be binding and conclusive upon all persons.

3.3 Election of Optional Benefits

A Participant may elect under this Plan to receive one or more of the Optional Benefits. If a Participant elects one or more of the Optional Benefits and the Employer's non-elective Contributions are not sufficient to cover the Participant's share of the costs of such Optional Benefits, the Participant's cash compensation will be redirected according to a Contribution and Benefit Election, and an amount equal to the redirection will be contributed by the Employer to the election Optional Benefit Plan, so elected to cover the Participant's share of the cost of each such Benefit as determined by the Employer. The balance of the cost of each of the Optional Benefits shall be paid by the Employer under this Plan with non-elective Employer Contributions.

If a Participant elects one or any combination of the Optional Benefits, the Participant's cash Compensation will be redirected according to a Contribution and Benefit Election and an amount equal to the redirection will be credited by the Employer to an expense account in accordance with the Health Care FSA and the Dependent Care FSA as applicable.

3.4 Employer and Participant Contributions

- **Employer Contributions.** The Employer may, but is not required to, contribute to any of the Benefit Options.

- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. In some instances, the participant may elect to make such Contributions with after-tax monies. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

3.5 Computing Salary Reduction Contributions

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:

    - The annual election for such Benefits payable on a per pay period basis in the Period of Coverage;

- An amount otherwise agreed upon between the Employer and the Participant; or
- An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)

- **Salary Reductions Following a Change of Elections.** If the Participant changes their election under the **HCFSA** or **DCFSA,** as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:
  - An amount equal to:
    - The new annual amount elected pursuant to Section 5 (Method of Timing and Elections);
    - Less the aggregate Contributions, if any, for the period prior to such election change;
    - Payable over the remaining term of the Period of Coverage commencing with the election change;
      - An amount otherwise agreed upon between the Employer and the Participant; or
      - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)

- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.

- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.

3.6 Funding This Plan

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

- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. On behalf of the Plan Administrator, the third-party administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.

- **Maximum Employer Contributions.** The maximum amount of Employer Contributions under the Plan for any Participant shall be the sum of:

    - The non-elective Employer Contributions

    - The maximum amount a Participant may receive in the form of health care reimbursements under the Health FSA, as dependent care assistance under the Dependent Care FSA respectively; and

    - The costs to the Participant from time to time of the applicable elected Benefits

Section 4 Eligibility and Participation

4.1 Eligibility to Participate

An individual is eligible to participate in this Plan if such individual meets the definition of Employee as set forth in Section 2 (Glossary).

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

4.2 Required Salary Reduction Agreement

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

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

4.3 Automatic Termination of Election

If a Participant fails to make the required Contribution payments, if any, with respect to an Optional Benefit, the Benefit mat cease to be provided to the Participant under the Plan at the end of the last pay period for which the last required Contribution was made. The Participant may be prohibited from making a new election for the remainder of the Plan Year except as provided in Section 6 (Irrevocability of Elections and Exceptions). Elections made under this Plan (or deemed to be made under Section 3.5) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or Benefits under the elected Optional Benefits may continue if and to the extent provided by such plans, as described in the Component Benefit Plans or as required by any state or federal law.

4.4 Termination of Participation

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

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;

- The date the Participant revokes their election to participate under a circumstance in which such change is permitted under the terms of this Plan;

- The termination of this Plan; or

- The date on which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable, as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year;

Notwithstanding the foregoing, such termination or participation shall not affect a former Participant's right to continue to participate in or receive Benefits under any other Employee Benefit Plan of the Employer under which the Participant is covered to the extent permitted by such Plan or required by applicable law. Reimbursement from the Health Care FSA and the Dependent Care FSA after termination of participation will be made pursuant to the Health Care Flexible Spending Account and the Dependent Care Spending Account.

4.5 Rehired Employees

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

4.6 Participation during Leaves of Absence

Any Participant who is not at work because of a paid Leave of Absence shall continue their Optional Benefit elections under the Plan in accordance with the Component Plans and the written Leave of Absence policies of the Employer. To continue their Optional Benefits, the Participant must have elections in place prior to the commencement of the Leave of Absence. Regular deductions from the Participant's Compensation will continue during the Leave of Absence.

Any Participant who is not at work because of an unpaid FMLA leave, leave for duty in the Uniformed Services, or due to any other approved unpaid Leave of Absence, may, at the Participant's option, continue certain Optional Benefits under the Plan that the Participant elected prior to the Leave of Absence. The following shall be determined in accordance with the written Leave of Absence policies of the Employer, the Component Plans, and any applicable law, including FMLA and USERRA:

i. Whether such Optional Benefits are available for continuation during an unpaid Leave of Absence;

ii. Whether payment for such Optional Benefits continues during a Leave of Absence; and

iii. The period of time for which such continuation of such Optional Benefits shall be available.

Any Participant returning from an FMLA, USERRA leave, or other approved unpaid Leave of Absence shall be reinstated in the same or equivalent benefits to the Optional Benefits they received prior to the unpaid Leave of Absence, adjusted for any changes in benefits that affected the workforce as a whole. Such reinstatement

shall be made in accordance with the written Leave of Absence policies of the Employer, the Component Plans, and any applicable law. If no Optional Benefits election was made before the Leave of Absence commenced, the Participant will have Default Coverage as described in Section 6 (Irrevocability of Elections and Exceptions).

Section 5 Method of Timing and Elections

5.1 Initial Election

An Eligible Employee's election for coverage shall be effective on the date of eligibility, or for any subsequent Plan Year, in accordance with this Plan's election procedures. An Employee must complete, sign and return a Salary Reduction Agreement within the election-period set forth therein to enroll in the Benefit Options. The Employer may, in lieu of a Salary Reduction Agreement, provide an electronic method for Employees to use to make elections. The Employer may require Employees to use the electronic system to make elections. Use of an electronic system will have the same effect as a signed Salary Reduction Agreement.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the date of eligibility.

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

5.2 Open Enrollment

During each Open Enrollment Period, the Plan Administrator shall provide a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction Agreement shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete, sign, and return the Salary Reduction Agreement to the Plan Administrator on or before the last day of the Open Enrollment Period. At the discretion of the of the Plan Administrator, such election information shall allow for "active elections" for the Health Care FSA and the Dependent Care FSA and "negative elections" (or "passive elections") for the Optional Benefits. In the Plan Administrator's discretion, elections under the Plan may be made in writing or electronically.

Each Participant who desires one or more Optional Benefits for the Plan Year shall so specify on the appropriate election form or forms, if necessary, and shall agree to a redirection in Compensation (pre-tax or post-tax depending on the Optional Benefit elected). The amount of the redirection in the Participant's Compensation for the Plan Year shall equal the allocated costs of the Optional Benefits elected by the Participant, subject to the limitations of the Health Care FSA and the Dependent Care FSA, less the amount of non-elective Employer Contributions (if any) on behalf of such Participant. The amount of the redirection in Compensation shall be adjusted automatically in the event of a change in cost of any of the Optional Benefit, in accordance with any rules issued by the Internal Revenue Service.

Each required election form must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the Plan Year, or at the discretion of the Plan Administrator, within a reasonable period of time after the beginning of the Plan Year. Once completed by a Participant, the election form shall remain in effect until subsequently modified, revoked, or changed by the Participant in accordance with Plan Sections 6.3 and 6.4.

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

5.3 Failure to Elect

If an Employee fails to complete, sign, and return a Salary Reduction Agreement, or fails to complete an election using the electronic system (if any) provided by the Employer within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive their entire Compensation in cash.

Such Employee may not enroll in the Plan until the next Open Enrollment Period or until an event occurs that would justify a mid-year election change as described in Section 6 (Irrevocability of Elections and Exceptions).

Section 6 Irrevocability of Elections and Exceptions

6.1 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section 6.

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

6.2 Procedure for Making New Election If Exception to Irrevocability Applies

- **Timing for Making New Election if Exception to Irrevocability Applies**. A Participant may make a new election within 31 days of the occurrence of an event described in Section 6.4 below if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event.

- **Effective Date of New Election**. Elections made pursuant to this Section 6 shall be effective on the 1st of the month following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election, unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.

- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document.

- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the **HCFSA** or **DCFSA** also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

    - Any Contributions made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election; to

    - The total Contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Benefit Option; reduced by

    - All reimbursements made during the entire Period of Coverage.

6.3 Change in Status Defined

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events

described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

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

- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the **DCFSA**, a change in the number of Qualifying Individuals as defined in Code Section 21(b)(1);

- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:

    - A termination or commencement of employment;

    - A strike or lockout;

    - A commencement of or return from an unpaid leave of absence;

    - A change in worksite; or

    - If the eligibility conditions of this Plan or another employee benefit plan of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;

- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and

- **Change in Residence.** A change in the place of residence of the Participant, Spouse, or Dependent(s).

6.4 Events Permitting Exception to Irrevocability Rule

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

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

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

- **Termination of Employment**. A Participant's election will terminate upon termination of employment as described in Section 4 (Eligibility and Participation).

- **Leave of Absence**. A Participant may change an election upon a leave of absence as described in Section 4 (Eligibility and Participation)

- **HIPAA Special Enrollment Rights (Applies to Health Plan only).** If a Participant or their Spouse or Dependent is entitled to special enrollment rights under a group Health Plan, as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election for group Health Plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

    - A Participant or their Spouse or Dependent declined to enroll in a group Health Plan coverage because they have other coverage and subsequently eligibility for such coverage is lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and Employer Contributions for such coverage were terminated; or

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

    - A Participant or their dependents experience a loss of eligibility for Medicaid or state Children's Health Insurance Program (CHIP) and the Participant requests enrollment within 60 days after that coverage ends, or if a Participant or their Dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and the Participant requests enrollment within 60 days after the determination or eligibility for such assistance.

- **Change in Status**. *(Applies to all Optional Benefits (medical, Rx, dental and vision), the Healthcare FSA and Dependent Care FSA as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer, referred to as the general consistency requirement.

  A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

  Election changes may be made to drop coverage altogether due to these events: termination of employment or other event that causes the Participant to become ineligible; divorce; or death of a Spouse or Dependent. The Plan Administrator, on a uniform and consistent basis, shall

determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement.

Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

- **Loss of Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under the circumstances would fail to correspond with the Change in Status.

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

- **Special Consistency Rule for DCFSA Benefits.** With respect to the **Dependent Care FSA**, the Participant may change or terminate the Participant's election upon a Change in Status if:

  - Such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an Employer's plan; or

  - The election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code Section 129.

- **Certain Judgments, Decrees and Orders.** (*Applies to the **Optional Benefits** (medical, Rx, dental and vision) and **Healthcare FSA** but does not apply to the **Dependent Care FSA***). If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a Qualified Medical Child Support Order (QMCSO) requires accident or health coverage, including an election for **HCFSA** Benefits for a Participant's Dependent child, a Participant may:

  - Change an election to provide coverage for the Dependent child provided that the order requires the Participant to provide coverage; or

  - Change an election to revoke coverage for the Dependent child if the order requires that another individual provide coverage under that individual's plan and such coverage is actually provided.

- **Medicare and Medicaid.** (*Applies to the **medical plan** and **Healthcare FSA**, but does not apply to the **Dependent Care FSA***). If a Participant, Spouse, or Dependent is enrolled in the medical Plan and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of Benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively cancel, but not reduce, the health coverage (including **Healthcare FSA** coverage) of the person becoming entitled to Medicare or Medicaid. However, such cancellation will not be effective to the extent that it would reduce future Contributions to the **Healthcare FSA** to a point where the total Contributions for the Plan Year are less that the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase coverage under the Medical Plan (including **Healthcare FSA** coverage).

- **Change in Cost.** *(Applies to the **Optional Benefits** (medical, Rx, dental and vision) and to the **Dependent Care CFSA** as limited below, but does not apply to the **Healthcare FSA**).* For purposes of this Section 6, "similar coverage" means coverage for the same category of Benefits for the same individuals.

    - **Insignificant Cost Changes.** The Participant is required to increase their elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants' elective Contributions on a prospective basis.

    - **Significant Cost Increases**. If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:

        - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;

        - Revoke the election for that coverage and, in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or

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

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

    - **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit (such as the premium for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:

- Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective contributions by decreasing their Salary Reduction;

- Participants who are enrolled in another benefit package option may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or

- Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant.

  - **Limitation on Change in Cost Provisions for Dependent Care FSA Benefits.** The above "Change in Cost" provisions apply to **DCFSA** Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

- **Change in Coverage.** (*Applies to the **Optional Benefits** (medical, Rx, dental and vision) and **Dependent Care FSA**, but not to the **Healthcare FSA)***. The definition of "similar coverage" applied in the Change of Cost provision above also applies here.

  - **Significant Curtailment.** Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is "significantly curtailed," Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is "significant" and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.

    - **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Option (or the Participant's, Spouse's, or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Option if offered, that provides similar coverage.

    - **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's, Spouse's, or Dependent's coverage under the respective employer's plan) is significantly curtailed and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and may either prospectively elect coverage under another Benefit Option that provides similar coverage or drop coverage if no other Benefit Option providing similar coverage is offered by the Employer.

    - **Definition of Loss of Coverage.** For purposes of this Section 6, a "Loss of Coverage" means a complete loss of coverage. In addition, the Plan Administrator in its sole discretion and on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- A substantial decrease in the health care providers available under the Benefit Package Plan;

- A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or their Spouse or Dependent is currently in a course of treatment; or

- Any other similar fundamental loss of coverage.

- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:

  - Participants who are enrolled in a Benefit Option other than the newly added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and

  - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of or significant improvement in a Benefit Option.

- **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan, including a plan of the Employer or a plan of the Spouse's or Dependent's employer, so long as:

  - The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or

  - The Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan.

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

- **Change in Dependent Care Service Provider**. A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:

  - If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

- If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section 6 must do so in accordance with the procedures described herein.

- **Purchase of Minimum Essential or Qualified Health Plan Coverage** (Applies to Health Plan only). A Participant who elected to salary reduce through the Section 125 Cafeteria Plan for the cost of health coverage shall be allowed to prospectively revoke their election with respect to the Section 125 Cafeteria Plan provided that the following conditions are met:

  - Conditions for revocation due to reduction in hours of service.

    (A) The Participant must have been in an employment status in which the Participant was reasonably expected to average at least thirty hours per week and there has been a change in employment status such that the Participant is reasonably expected to work less than thirty hours per week, even if the reduction does not result in the Participant ceasing to be eligible under the Health Plan, and

    (B) The revocation of the election of coverage under the Health Plan corresponds with the intended enrollment of the Participant, and any other Plan Participants who cease coverage due to the revocation, in another plan that provides minimum essential coverage, with the new coverage to be effective no later than the first day of the second month following the month that includes the revocation of coverage.

    (C) The Plan may rely on the reasonable representation of a Participant in regard to such a revocation.

  - Conditions for revocation due to enrollment in a Qualified Health Plan.

    (A) The Participant must (i) be eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace, or (ii) seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual enrollment period, and

    (B) The revocation of the election of coverage under the Health Plan corresponds with the intended enrollment of the Participant, and any other Plan Participants who cease coverage due to the revocation, in a Qualified Health Plan through a Marketplace for new coverage to be effective no later than the day immediately following the last day of the coverage that is being revoked.

(C) The Plan may rely on the reasonable representation of a Participant in regard to such a revocation.

- **Purchase of Minimum Essential or Qualified Health Plan Coverage for Family Members** (Applies to Health Plan only). A Participant who elected to salary reduce through the Section 125 Cafeteria Plan for the cost of health coverage, may revoke their elections for family coverage mid-year to allow one or more family members to prospectively revoke their election with respect to the Section 125 Cafeteria Plan provided that the following conditions are met:

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

    (A) The family member(s) must (i) be eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace, or (ii) seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual enrollment period, and

    (B) The revocation of the election of coverage under the Health Plan corresponds with the intended enrollment of the family member(s)in a Qualified Health Plan through a Marketplace. The new coverage is to be effective no later than the day immediately following the last day of the coverage that is being revoked.

    (C) The Plan may rely on the reasonable representation of a Participant in regard to such a revocation.

6.5 Election Modifications Required by Plan Administrator

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

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;

- Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized;

- Maintain the qualified status of Benefits received under this Plan; or

- Satisfy any of the Code's nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans.

  In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant beginning with the Participant in the class who had elected the highest Salary Reduction amount and

continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 7 Plan Administration

7.1 Plan Administrator

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

7.2 Powers of the Plan Administrator

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

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan (provided that the State of Delaware's State Employee Benefits Committee shall exercise such exclusive power with respect to an appeal of a claim);

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

- To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

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

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

- To receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

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

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

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

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

7.3 Records of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall by open to inspection by the Employer. The Plan Administrator shall prepare and submit to the Employer an annual report, which shall include such information as the Plan Administrator deems necessary or advisable.

7.4 Examination of Records

The Plan Administrator shall make available to each Participant such of their records under the Plan as pertain to them including benefit elections, mid-year plan changes and any documentation submitted in accordance with those, for examination at reasonable times during normal business hours.

7.5 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the Participant's direction, information, or election as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by the Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator. All actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

7.6 Outside Assistance

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

7.7 Named Fiduciary

The Employer and Plan Administrator shall be the "Named Fiduciary" of the Plan and shall have only those duties, responsibilities, and obligations (referred to collectively as "fiduciary duties") as specifically are given them under the Plan or as otherwise are imposed by applicable law.

7.8 Fiduciary Liability

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

7.9 Employer Duties

All responsibilities not specifically delegated to another Named Fiduciary in this Plan document remain with the Employer. The Employer shall have the sole authority to appoint, terminate, remove, and replace the Plan Administrator or other Named Fiduciaries.

7.10 Inability to Locate Payee

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

7.11 Plan Administrator to Keep Accurate Records

The Plan Administrator shall keep accurate records and minutes of the proceedings and actions with respect to the Plan. The Plan Administrator shall maintain, or cause to be maintained, books and records showing the operation and condition of the accounts established pursuant to the Plan. The Plan Administrator shall take all measures necessary to ensure that the amounts under the Contribution and Benefit Election of a Participant are used exclusively for such Participant's benefit under the Component Benefit Plans.

7.12 Effect of Mistake

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

7.13 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data, including but not limited to Benefits or Governance Committee meeting minutes regarding this plan and correspondence that relates to the plan and changes being considered, shall be available to any Participant, Employee, or an Employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator or the business office of the Employer.

7.14 Administrative Expenses

All expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist or other person who shall be employed by the Plan Administrator in connection with the administration, shall be paid by the Employer.

7.15 Delegation

The Plan Administrator may authorize one or more of its members or any agent to make any payment on its behalf, or to execute or deliver any instrument on its behalf.

7.16 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates another person to be such agent.

Section 8 Amendment or Termination of the Plan

8.1 Permanency

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

8.2 Right to Amend

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

Any amendment or restatement shall be deemed to be duly executed by the Employer when signed by the Co-Chair of the State of Delaware's State Employee Benefits Committee (SEBC) and attested by its Secretary.

8.3 Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan in whole or in part at any time without prejudice. This Plan also shall terminate automatically if the Employer is legally dissolved, makes a general assignment for the benefit of its creditors, files for liquidation under the Bankruptcy Code, merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the Participant and Dependents.

Section 9 General Provisions

9.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Schedules A and B and then by the Employer.

9.2 No Contract of Employment

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

9.3 Written Notice

Any written notice provided under this Plan shall be deemed received by a Participant or Eligible Employee if sent by regular mail, postage prepaid, to the last address of the Participant or Eligible Employee on the records of the Plan Administrator. Any electronic notice provided under this Plan shall follow the U.S. Department of Labor's electronic disclosure requirements set forth in 29 C.F.R. § 2550.104b-1(c).

9.4 Compliance with Federal Mandates

To the extent applicable for each Benefit Option, the Plan will provide Benefits in accordance with the requirements of all federal mandates, including USERRA, COBRA, and HIPAA. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

9.5 Verification

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

9.6 Limitation of Rights

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

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or

- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

9.7 Non-Assignability of Rights

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

9.8 Governing Law

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

9.9 Severability

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

9.10 Captions

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

9.11 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the IRS, to the extent this Plan document or any Schedule contains advice relating to a federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code or promoting, marketing, or recommending to another party any transaction or matter addressed herein.

9.12 No Guarantee of Tax Consequences

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

9.13 Indemnification of Employer

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

9.14 No Vested Interest

Except for the right to receive any benefit payable under the Plan, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

9.15 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan and the applicable Component Benefit Plan regardless of whether any Contributions with respect to a Participant have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such Contributions will be made.

9.16 Waiver

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppels against enforcing any provision of the Plan, except in writing by Plan Administrator. No such written waiver shall be deemed a continuing waiver unless explicitly made so and shall operate only with regard to the specific term or condition waived and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

Section 10 HIPAA Privacy and Security

10.1 Provision of Protected Health Information to Employer

For purposes of this Section 10, Protected Health Information ("PHI") shall have the meaning as defined in HIPAA. PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the medical, prescription drug, dental, vision, and HCFSA plus any other Benefit Option which might be subject to the privacy and security provisions of HIPAA (hereinafter referred to collectively as the Plan). When this health information is provided to the Employer, it is PHI. HIPAA and its implementing regulations restrict the Employer's ability to use and disclose PHI. The Employer shall have access to PHI from the Plan only as permitted under this Section 10 or as otherwise required or permitted by HIPAA.

10.2 Permitted Disclosure of Enrollment/Disenrollment Information

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

10.3 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and

- From which the required information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

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

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification described below, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan Administration Purposes.

"Plan Administration Purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administration Purposes

do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

10.5 Conditions of Disclosure for Plan Administration Purposes

With respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, the Employer shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

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

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

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

- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

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

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

- Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

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

10.6 Adequate Separation Between Plan and Employer

The Employer shall designate such employees of the Employer who need access to PHI in order to perform Plan administration functions that the Employer performs for the Plan such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals. No other persons shall have access to PHI. These specified employees, or classes of employees, shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan.

In the event that any of these designated employees do not comply with the provisions of this Section 10, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 10 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

10.7 Certification of Plan Sponsor

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 10.5.

10.8 Organized Health Care Arrangement

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Option under a covered health plan under 45 CFR § 160.103 provided by Employer.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the State of Delaware Cafeteria Benefits Plan, State of Delaware has caused this Plan to be executed in its name and on its behalf, on this 9 day of September, 2024.

State of Delaware

By: Faith L. Rentz

Faith L. Rentz
Director, Statewide Benefits Office and Insurance Coverage

Appendix A Covered Expenses - Healthcare FSA

The Healthcare FSA is an account that allows participants to put money aside to reimburse themselves for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while covered under the account. Participants may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which a participant is obligated to pay, and which are not covered by any plan. This may include amounts that are not paid by employer-sponsored health care plans, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. Bills may also be submitted for medical, prescription drug, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses could have been claimed on an individual income tax return (Form 1040).

Appendix B State Organizations and Related Employers That Have Adopted This Plan

With the Approval of State of Delaware.

State of Delaware employees of State agencies, school districts, and charter schools
Delaware State University
Delaware Technical Community College

No Related Employers have adopted this Plan. State of Delaware is the only Employer participating in this Plan.

Schedule A Health Care Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule A shall have the same meaning as the defined terms in the Plan document ("Plan Document") to which this Schedule A is attached.

A.1 Benefits

An Employee not enrolled in an HSA can elect to participate in the HCFSA by electing to receive Benefits in the form of reimbursements for Health Care Expenses. If elected, the Benefit Option will be funded by Participant Contributions on a pre-tax Salary Reduction basis as provided in the Section 3.4 (Employer and Participant Contributions) of the Plan Document.

Unless an exception applies as described in Section 6 (Irrevocability of Elections and Exceptions) of the Plan Document, such election is irrevocable for the duration of the Period of Coverage to which it relates.

A.2 Eligibility

Employees shall be eligible to participate in the Health Care FSA Program in accordance with the provisions of the State of Delaware Cafeteria Benefits Plan. Such State of Delaware Cafeteria Benefits Plan shall govern the terms of eligibility and participation generally, supplemented by the provisions of Schedule A of the Health Care Flexible Spending Account.

A.3 Determination of Eligibility by Plan Administrator

The determination of an Employee's eligibility to participate in the Health Care FSA Program shall be made by the Plan Administrator, and the Plan Administrator's good faith determination shall be binding and conclusive upon all persons.

A.4 Commencement of Participation

An Eligible Employee shall become a Participant under the Health Care FSA Program at the same time he or she becomes eligible to participate in the Health Plan, provided that the Eligible Employee has timely filed with the Plan Administrator a Contribution and Benefit Election as provided in the State of Delaware Cafeteria Benefits Plan.

A.5 Reinstatement of Former Participant

A former Participant shall become a Participant again in accordance with the provisions of Section 4.5 of the Plan Document if and when he or she meets the eligibility requirements of Section 3.1 and elects a Coverage Option described in Section 4.2.

A.6 Participation During Leaves of Absence

a. Any Participant, who is not at work because of a paid Leave of Absence, shall continue their Health Care FSA election under the Health Care FSA Program in accordance with the written Leave of Absence policies of the Employer, the Component Benefit Plans, and applicable law. To continue the Health Care FSA election, the Participant must have an election in place prior to the commencement of the Leave of Absence. Deductions will continue to be withheld during the paid Leave of Absence. Missed deductions, if any, will be collected in arrears when the Participant returns to work.

b. Any Participant who is not at work because of an unpaid FMLA leave, leave for duty in the Uniformed Services, or due to any other approved unpaid Leave of Absence, may, at the Participant's option, continue the Health Care FSA election under the Plan that the Participant elected prior to the Leave of Absence so long as the Participant continues to make any required Contributions on an after-tax basis or so long as the Participant's Contributions are collected in arrears when the Participant returns to work. The following shall be determined in accordance with the written Leave of Absence policies of the Employer, the Component Benefit Plans, and any applicable law, including FMLA and USERRA:

   i. Payment for such Health Care FSA elections continued during a Leave of Absence; and

   ii. The period of time for which such continuation of Health Care FSA elections shall be available.

c. Any Participant returning from a FMLA, USERRA leave, or other approved unpaid Leave of Absence during the same Plan Year shall be reinstated in the same or equivalent elections to the Health Care FSA elections they received prior to the Leave of Absence, adjusted for any changes in Benefits that affected the workforce as a whole. Such reinstatement shall be made in accordance with the written Leave of Absence policies of the Employer, the Component Benefit Plans, and any applicable law. If no Health Care FSA election was made before the Leave of Absence commenced, the Participant will have Default Coverage, unless the Participant experienced a qualifying change in status as described in Section 6 of the State of Delaware Cafeteria Benefits Plan. (See A.18 for information on Qualified Reservist Distribution).

A.7 Continuation Coverage

If and to the extent required by law (including, without limitation, Code Section 4980B), in the event coverage under the Health Care FSA Program ceases due to a Participant's death, termination of employment, reduction in work hours, divorce or legal separation from their Spouse, a Dependent child ceasing to be a Dependent child under the Health Care FSA Program or other events prescribed by law, continued coverage under this Health Care FSA Program shall be made available to the Participant and/or Spouse, or Dependent of a Participant or former Participant under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). In that event, such Spouse, or Dependent shall be treated as a Participant under this Health Care FSA Program, but only to such extent and for such period as COBRA law requires.

For post-tax payment of COBRA benefits, no Contribution and Benefit Election shall be required for a Participant, Spouse, or Dependent, but another form of election may be required. Any post-tax Contributions must be paid to the Employer or designee on a monthly basis (or within such other time limit as may be provided for by law), and coverage shall cease upon nonpayment of any such required Contributions.

The Health Care FSA Program is intended to comply with the continuation of health care coverage requirements set forth in Code Section 4980B.

A.8 Death

A Participant's beneficiaries or representative of the Participant's estate may submit claims for expenses that the Participant incurred through the end of the month in which the Participant ceases to be eligible for the Plan due to death. A Participant may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement. While any claims must have been incurred prior to the end of the month in which the Participant dies, the claims may be submitted until the last day of the normal claims runoff period.

A.9 Benefit Contributions

The annual Contribution for a Participant's **HCFSA** is equal to the annual Benefit amount elected by the Participant.

A.10 Eligible Health Care Expenses

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

- **Incurred**. A Health Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

- **Health Care Expenses**. Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent(s) covered under the **HCFSA** for medical care, as defined in Code Section 213(d), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan.

- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the **HCFSA**. Other expenses that are not reimbursable are listed in Section 213 of the Internal Revenue Code.

A.11 Maximum and Minimum Benefits

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum dollar amount elected by the Participant for reimbursement of Health Care Expenses incurred during a Period of Coverage, reduced by prior reimbursements during the Period of Coverage, shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's **HCFSA**. Notwithstanding the foregoing, no reimbursements will be available for Health Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided below or is entitled to submit expenses incurred during a Grace Period as provided below.

- **Payment** shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, or during a Grace Period as provided below, provided that the other requirements of this Section have been satisfied.

- **Maximum and Minimum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under the Plan in the form of reimbursements for Health Care Expenses incurred in any subsequent Period of Coverage shall be no greater than the federally allowed maximum. The maximum annual benefit amount shall be set by the Employer and communicated to the employees through the use of the enrollment system or enrollment election forms. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be $125. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's **HCFSA**.

- **Changes**. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.

- **No Proration**. If a Participant enters the Plan mid-year or wishes to increase their election mid-year as permitted under the Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.

- **Effect on Maximum Benefits If Election Change Permitted**. Any change in an election affecting annual Contributions to the **HCFSA** will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing on the election change Effective Date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding:

    - The aggregate Contribution for the period prior to such election change;

      to

- The total Contribution for the remainder of such Period of Coverage to the HCFSA;

  reduced by

- All reimbursements made during the entire Period of Coverage.

A.12 Establishment of Account

The Plan Administrator will establish and maintain a **HCFSA** with respect to each Participant who has elected to participate in the **HCFSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts**. A Participant's **HCFSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- **Debiting of Accounts**. A Participant's **HCFSA** will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage, or during a Grace Period described below.

- **Available Amount Not Based on Credited Amount**. The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this Section above. It is not based on the amount credited to the **HCFSA** at a particular point in time.

A.13 Use It or Lose It Rule; Forfeiture of Account Balance

- **Use It or Lose It Rule.** Except for expenses incurred during an applicable Grace Period, if any balance remains in the Participant's **HCFSA** for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

- **Use of Forfeitures**. All forfeitures under this Plan shall be used as follows:

  - First, to offset any losses experienced by Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;

- Second, to reduce the cost of administering the HCFSA during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and

- To provide increased Benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

- **Unclaimed Benefits.** Benefit payments that remain unclaimed by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.

A.14 Grace Period

- **Special Rules for Claims Incurred During a Grace Period.** The Employer has the discretion to establish a grace period following the end of the Plan Year, as follows:

  - An individual may be reimbursed for Health Care Expenses incurred during a Grace Period from amounts remaining in their **HCFSA** Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year **HCFSA** Amounts") if the individual is either:

    - A Participant with **HCFSA** coverage that is in effect on the last day of that Plan Year; or

    - A qualified beneficiary as defined under COBRA who has COBRA coverage under the **HCFSA** Benefit Option on the last day of that Plan Year.

  - Prior Plan Year **HCFSA** Amounts may not be cashed out or converted to any other taxable or non-taxable Benefit Option. For example, Prior Plan Year **HCFSA** Amounts may not be used to reimburse Dependent Care Expenses.

  - Health Care Expenses incurred during a Grace Period and approved for reimbursement will be reimbursed first from any available Prior Plan Year **HCFSA** Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. If the **HCFSA** is accessible by an electronic payment card, Health Care Expenses incurred during the Grace Period may need to be submitted manually in order to be reimbursed from Prior Plan Year **HCFSA** Amounts if the card is unavailable for such reimbursement. An individual's Prior Plan Year **HCFSA** Amounts will be debited for any reimbursement of Health Care Expenses incurred during the Grace Period that is made from such Prior Plan Year **HCFSA** Amounts.

  - Claims for reimbursement of Health Care Expenses incurred during a Grace Period must be submitted no later than 4 months following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year **HCFSA** Amounts. Any Prior Plan Year **HCFSA** Amounts that remain after all reimbursements have been made for the Plan Year

and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures.

A.15 Reimbursement Procedure

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

- **Claims Substantiation**. A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:

  - The person or persons on whose behalf Health Care Expenses have been incurred;

  - The nature and date of the expenses incurred, and, if such person is not the Participant requesting the reimbursement, the relationship of such person to the Participant;

  - The amount of the requested reimbursement;

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

  - Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise.

  The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. If the **HCFSA** is accessible by an electronic payment card, the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with the most current IRS guidance.

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

- **Claim Denial.** If a claim for reimbursement under the **HCFSA** or **DCFSA** is wholly or partially denied, or if the Participant is denied a Benefit under the Plan regarding the Participant's coverage under the Plan, then the claims procedure described below will apply.

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

        - The specific reasons for the denial;

        - The specific Plan provisions on which the denial is based;

        - A description of any additional material or information necessary to validate the claim, if applicable and an explanation of why such material or information is necessary; and

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

    - **First Level Appeal to ASI.** If a claim is denied in whole or in part the Participant or the Participant's authorized representative may request a review of the adverse benefits determination upon written application to ASI. The Participant or the Participant's authorized representative may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review. An appeal of an adverse benefits determination must be made in writing within 30 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

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

  - The specific reasons for the decision on review;

  - The specific Plan provisions on which the decision is based;

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

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

- **Second and Final Level Appeal to the Statewide Benefits Office.** Participant may file an appeal of the denial in writing to the Statewide Benefits Office within 20 days of the postmark date of the notice of denial of the first level appeal. Such appeal shall be sent to:

  Appeals Administrator
  RE: APPEAL
  Statewide Benefits Office
  841 Silver Lake Boulevard
  Suite 100
  Dover, Delaware 19904

The appeal must contain how the employee may be contacted (mailing address, telephone number, etc.), a written summary of events, applicable claims, and any additional documentation Participant desires to provide to support their position.

The Appeals Administrator from the Statewide Benefits Office (or their designee) will conduct an internal review of the appeal and provide a written notice of the decision to the Participant and the third-party administrator within 30 days of receiving the appeal.

A.16 Termination of Participation

An Employee's participation in the Health Care FSA Program shall terminate as of the earlier of:

a. The date on which the Health Care FSA Program terminates; or

b. The date on which he ceases to be an Employee eligible to participate in accordance with the provisions of Section 3.1 of the Health Care FSA Program; or

c. The date on which their election to receive Qualifying Health Care Expense reimbursement expires or is terminated under the State of Delaware Cafeteria Benefits Plan (unless a new such election is effective immediately thereafter); or

d. The date on which he fails to pay any required Contributions (including payment under a Contribution and Benefit Election made under the Cafeteria Benefits Plan);

provided, however, that such termination of participation shall not affect a former Participant's right to continue to participate in or to receive Benefits under any employee benefit plan of the Employer under which the Participant is covered to the extent permitted by such plan or required by applicable law.

A.17 Reimbursements After Termination; Limited COBRA Continuation

The Participant will not be able to receive reimbursements for Health Care Expenses incurred after participation terminates. However, except for expenses incurred during an appropriate Grace Period, such Participant, or the Participant's estate, may claim reimbursement for any Health Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim by the date established in the Reimbursement Procedure paragraphs above following the close of the Plan Year in which the Health Care Expense was incurred.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and such Participant's Spouse and Dependent(s), whose coverage terminates under the **HCFSA** because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the **HCFSA** the day before the qualifying event, subject to all conditions and limitations under COBRA. The Contributions for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the Employee and the Employer plus a 2% administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining Contribution payments at the time of the qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified if the individual is eligible for COBRA continuation coverage.

If COBRA is elected, COBRA coverage will be subject to the most current COBRA rules. COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the **HCFSA** will cease at the end of the Plan Year, except for expenses incurred during an appropriate Grace Period, and cannot be continued for the next Plan Year. Coverage may terminate sooner if the Contributions for a Period of Coverage are not received by the due date established by the Plan Administrator for that Period of

Coverage. Continuation coverage is only granted after the Plan Administrator has received the Contributions for that Period of Coverage.

Contributions for coverage for **HCFSA** Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- Because the Employee ceases to be eligible because of a reduction of hours; or

- Because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage.

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

A.18 Qualified Reservist Distribution

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the **HCFSA**:

- The Participant's Contributions to the **HCFSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **HCFSA** for the Plan Year as of that date.

- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

- The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

- The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009 and continues on or after the date.
- During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant submits a qualified reservist distribution election form to the Plan Administrator.

Amount of Qualified Reservist Distribution. If the above conditions are met, the Participant will receive a distribution from the **HCFSA** equal to their Contributions to the **HCFSA** for the Plan Year as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

No Reimbursement for Expenses Incurred After Distribution Request. Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the **HCFSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **HCFSA** reimbursements for the Plan Year.

Tax Treatment of a Qualified Reservist Distribution. If the Participant receives a qualified reservist distribution, it will be included in their gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

A.19 Named Fiduciary

The Plan Administrator is the Named Fiduciary for the **HCFSA**.

A.20 Coordination of Benefits

HCFSAs are intended to pay Benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the **HCFSA** shall not be considered a group health plan for coordination of benefits purposes, and the **HCFSA** shall not be taken into account when determining benefits payable under any other plan.

Schedule B Dependent Care Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule B shall have the same meaning as the defined terms in the Plan document ("Plan Document") to which this Schedule B is attached.

B.1 Benefits

An Employee can elect to participate in the **DCFSA** to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in Section 6 (Irrevocability of Elections and Exceptions) of the Plan, such election is irrevocable for the duration of the Period of Coverage to which it relates.

B.2 Eligibility

Employees shall be eligible to participate in the Program in accordance with the provisions of the Section 125 Cafeteria Plan. Such Section 125 Cafeteria Plan shall govern eligibility and participation generally, supplemented by the provisions of this Schedule B.

Married employees are only Eligible Employees for the purpose of participating in the Dependent Care FSA if their Spouse:

a. works full-time or part-time outside the home; or

b. is actively looking for work; or

c. has no Earned Income for the year; and

i. is a full-time Student for at least five months of the year; or

ii. is incapable of caring for themselves or for the Dependent.

B.3 Determination of Eligibility by the Plan Administrator

The determination of an Employee's eligibility to participate in the Program shall be made by the Plan Administrator, and the Plan Administrator's good faith determination shall be binding and conclusive upon all persons.

B.4 Commencement of Participation

An Eligible Employee shall become a Participant under the Program provided that the Eligible Employee has timely completed an electronic election form and, if applicable, a Contribution and Benefits Election as provided in the Section 125 Cafeteria Plan.

B.5 Reinstatement of Former Participant

A former Participant shall become a Participant again in accordance with the provisions of Section 4.5 of the Plan if and when he meets the eligibility requirements of Section 3.1 and elects a Coverage Option described in Section 4.2.

B.6 Participation During Leaves of Absence

a. Any Participant who is not at work because of a paid Leave of Absence shall continue their Dependent Care FSA election under the Program in accordance with the written Leave of Absence policies of the Employer, the Component Benefit Plans, and applicable law.

b. Any Participant who is not at work because of an unpaid FMLA leave, leave for duty in the Uniformed Services, or due to any other approved unpaid Leave of Absence as defined in the Welfare Benefit Plan Summary Plan Description, may, at the Participant's option, continue their Dependent Care FSA election under the Program that the Participant elected prior to the Leave of Absence so long as the Participant continues to make any required Contributions or so long as the Participant's Contributions are collected in arrears when the Participant returns to work. The following shall be determined in accordance with the written Leave of Absence policies of the Employer, the Component Benefit Plans, and any applicable law, including FMLA and USERRA:

   i. Amount of the payment for such Dependent Care FSA elections continued during a Leave of Absence; and

   ii. The period of time for which such continuation of Dependent Care FSA elections shall be available.

c. Any Participant returning from an FMLA, USERRA leave, or other approved unpaid Leave of Absence in the same Plan Year shall be reinstated in the same or equivalent elections to the Dependent Care FSA elections they received prior to the Leave of Absence, adjusted for any changes in benefits that affected the workforce as a whole. Such reinstatement shall be made in accordance with the written Leave of Absence policies of the Employer, the Component Benefit Plans, and any applicable law. If no Dependent Care FSA election was made before the Leave of Absence commenced, the Participant will have Default Coverage, unless the Participant experienced a qualifying change in status as described in Section 6 of the Plan Document.

B.7 Death

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

Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement. While any claims must have been incurred prior to the end of the month in which the Participant dies, the claims may be submitted until the last day of the normal claims runoff period.

B.8 Benefit Contributions

The annual Contribution for a Participant's **DCFSA** Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below (B.10).

B.9 Eligible Dependent Care Expenses

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

- **Incurred.** A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

- **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be:

    - Employment-related expenses under Code Section 21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and

    - Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.

If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the **DCFSA** can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule B.

- **Qualifying Individual.** A Qualifying Individual is:

    - A tax dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1);

    - A tax dependent of the Participant as defined in Code Section 152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

    - A Participant's Spouse, as defined in Code Section 152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code Section 152(e).

- **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means services that both:

  - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the DCFSA and during the Period of Coverage; and

  - Are performed:

    - In the Participant's home; or

    - Outside the Participant's home for:

      - The care of a Participant's Dependent who is under age 13; or

      - The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household.

        In addition, if the expenses are incurred for services provided by a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

- **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:

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

  - A Participant's Spouse;

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

  - A Participant's Spouse's child, as defined in Code Section 152 (a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

B.10 Maximum and Minimum Benefits

- **Maximum Reimbursement Available and Statutory Limits.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts

credited to the Participant's **DCFSA** less amounts debited to the Participant's **DCFSA** pursuant to the Maximum Contribution paragraph below.

Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section B.10 have been satisfied.

No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year-to-date amount of Participant Contributions to the **DCFSA** for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limits.** The maximum dollar limit for a Participant is the smallest of the following amounts:
  - The Participant's Earned Income for the calendar year;
  - The Earned Income for the calendar year of the Participant's Spouse who:
    - Is not employed during a month in which the Participant incurs a Dependent Care Expense; and
    - Is either physically or mentally incapable of self-care or a full-time Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or
  - $5,000 for the calendar year ($2,500 in the event of a short plan year), if:
    - The Participant is married and files a joint federal income tax return; or
    - The Participant is married, files a separate federal income tax return, and meets the following conditions:
      - The Participant maintains as their home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
      - The Participant furnishes over half of the cost of maintaining such household during the taxable year; and
      - During the last six months of the taxable year, the Participant's Spouse is not a member of such household; or
    - The Participant is single or is the head of the household for federal income tax purposes.

- $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

- **Minimum Dollar Limits.** The minimum annual Benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $125.

- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.

- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase their election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.

- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the **DCFSA** component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change Effective Date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

  o The aggregate Contribution for the period prior to such election change;

  to

  o The total Contribution for the remainder of such Period of Coverage to the **DCFSA**;

  reduced by

  o All reimbursements made during the entire Period of Coverage.

B.11 Establishment of Account

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

- **Crediting of Accounts.** A Participant's **DCFSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- **Debiting of Accounts.** A Participant's **DCFSA** will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

- **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's **DCFSA**, less any prior reimbursements. A Participant's **DCFSA** may not have a negative balance during a Period of Coverage.

B.12 Grace Period and Unused Year End Balance

- **Grace Period**. The Employer has the discretion to establish a grace period following the end of the Plan Year as follows. If a Participant has unused funds in their **DCFSA** at the end of the Plan Year, such Participant is allowed to carry over the unused balance for reimbursement of Dependent Care Expenses incurred during the Grace Period. Unused funds in a Participant's **DCFSA** may not be used to reimburse another Benefit Option the Participant may have elected.
  The Grace Period shall begin immediately following the end of the Plan Year and terminate on the 15th day of the third calendar month after the end of the Plan Year.

- **Use It or Lose It Rule**. Except for expenses incurred in an applicable Grace Period, if any balance remains in the Participant's **DCFSA** after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during the subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

- **Use of Forfeiture**. All forfeitures shall be used by the Plan in the following ways:

  - To offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;

  - To reduce the cost of administering the **DCFSA** during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and

  - To provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with applicable regulations.

- **Unclaimed Benefits.** Any **DCFSA** Benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage or Grace Period in which the Dependent Care Expense was incurred shall be applied as described above.

B.13 Reimbursement Procedure

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

- **Claims Substantiation.** A Participant who has elected to receive **DCFSA** Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Plan Administrator by no later than the date set by the Plan Administrator each year, setting forth:

    - The person or persons on whose behalf Dependent Care Expenses have been incurred;

    - The nature and date of the expenses incurred;

    - The amount of the requested reimbursement;

    - The name of the person, organization or entity to whom the expense was or is to be paid;

    - The tax ID (or social security number, if the provider is an individual) number of the provider. No tax ID or social security number is required if the provider is a tax-exempt organization as described in Code Section 501(c)(3);

    - The name of the person for whom the expense was incurred and the relationship of such person to the Participant;

    - A written statement that the dependent care expense (or the portion thereof for which reimbursement is sought under the Program) has not been reimbursed and is not reimbursable under any other insurance arrangement or any other dependent care assistance plan coverage;

    - The Participant's certification that they have no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and

    - Other such details about the expenses that may be requested by the Plan Administrator.

    The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- **Claims Denied.** For appeals of claims that are denied, see the Appeals Procedure in Schedule A.

B.14 Report to Participants

During the first week of July, the Plan Administrator shall furnish to each Participant who has received reimbursement for Qualifying Dependent Care Expenses under the Plan during the prior calendar year a statement showing the amount of such reimbursement paid or expenses incurred during such year with respect to the Participant. In addition, the Plan Administrator shall report the amount of each Participant's Qualifying Dependent Care Expenses incurred during the prior calendar year on each Participant's Form W-2.

B.15 Disclosure of Dependent Care Services

It is the responsibility of each Participant to disclose identifying information regarding the Dependent Care Service Provider(s) on such Participant's annual income tax return. Identifying information is defined as the name, address, and, except for an organization described in Code Section 501(c)(3) and exempt for tax under Code Section 501(a), taxpayer identification number of the person(s) performing the qualified dependent care services. If such identifying information is not provided by the Participant, reimbursement for Qualifying Dependent Care Expenses received for such calendar year will not be excluded from gross income unless the Participant can show that he exercised due diligence in attempting to provide such information.

B.16 Termination of Participation

An Employee's participation in the Program shall terminate as of the earlier of:

a. The date on which the Program terminates;

b. The date on which he ceases to be an Employee eligible to participate in accordance with the provisions of Section 3.1 of the Plan; or

c. The date on which their election to receive Qualifying Dependent Care Expense reimbursement expires or is terminated under the Section 125 Cafeteria Plan (unless a new such election is effective immediately thereafter); or

d. The date on which he fails to pay any required Contributions (including payment under a Contribution and Benefit Election made under the Section 125 Cafeteria Plan);

Provided that such termination of participation shall not affect a former Participant's right to continue to participate in or to receive Benefits under any employee benefit plan of the Employer under which the Participant is covered to the extent permitted by such plan or required by applicable law.

B.17 Reimbursements After Termination

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred before their date of termination up to the amount of the Participant's remaining **DCFSA** Benefits.

B.18 DCFSA Participant vs. Claiming the Dependent Care Tax Credit

Employees often have the choice between participating in their employer's **DCFSA** on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code Section 21. Employees cannot take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.