Schedule D
Dependent Care Assistance Program

Unless otherwise specified, terms capitalized in this Schedule D shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

D.1 Benefits

An Employee can elect to participate in the **DCAP** 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 the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

D.2 Benefit Contributions

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

D.3 Eligible Dependent Care Expenses

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

- **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 §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 **DCAP** can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

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

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

  - A tax dependent of the Participant as defined in Code §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 §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 §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 **DCAP** 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 §151(c) to a Participant or Participant's Spouse;
  - A Participant's Spouse;
  - A Participant's child, as defined in Code §152(f)(l), 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 §152 (a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

D.4 Maximum Benefit

- **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 **DCAP** less amounts debited to the Participant's **DCAP** 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 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 **DCAP** for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limit.** 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 or the maximum allowed under federal regulations, 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 his or her 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, or the maximum allowed under federal regulation, if the Participant is married and resides with the Spouse, but files a separate federal income tax return.
  - For the 2021 Plan Year only, in accordance with the American Rescue Plan Act of 2021 (ARPA), the Maximum Dollar Limits in the previous two open bullets beginning "$5,000 for the

calendar year" and "$2,500 for the calendar year" are increased from $5,000 and $2,500 to $10,500 and $5,250, respectively. The qualifying criteria listed in these two open bullets are not otherwise altered by this increase. These increases constitute an Addition or Significant Improvement of a Benefit Option as described in section 6.4 above.

- **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 his or her 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 **DCAP** 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:

  - 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 **DCAP**; reduced by

  - All reimbursements made during the entire Period of Coverage.

D.5 Establishment of Account

The Plan Administrator will establish and maintain a **DCAP** with respect to each Participant who has elected to participate in the **DCAP**, 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 **DCAP** 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 **DCAP** 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 **DCAP**, less any prior reimbursements. A Participant's **DCAP** may not have a negative balance during a Period of Coverage.

D.6 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 his or her **DCAP** at the end of the Plan Year and the Participant is still an active Participant on the last day 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 **DCAP** 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 **DCAP** 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. Claims must be submitted on or before the **Claims Filing Deadline**.

- **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 **DCAP** 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 **DCAP** 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.

D.7 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 **DCAP** 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 **Claims Filing Deadline**, 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;
- A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;
- The Participant's certification that he or she has 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 the Plan Document.

D.8 Reimbursements After Termination

If a Participant's employment terminates, the Participant may submit for reimbursement Dependent Care Expenses incurred before the last day of the Plan year (even if after the date of termination) up to the amount of the Participant's remaining **DCAP** Benefits. As a clarification: A participant who terminates coverage before the last day of the Plan Year will not be reimbursed for expenses incurred during the Grace Period associated with that Plan Year. A terminated participant may only be reimbursed for expenses incurred during the participant's period of coverage (DCAP participants' coverage ceases on the last day of the Plan year).

D.9 DCAP Participant vs. Claiming the Dependent Care Tax Credit

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

Schedule E
Dental/Vision Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule E shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

E.1 Benefits

A Benefit Eligible Employee not enrolled in the **Health FSA** can elect to participate in the **Dental/Vision FSA** by electing to receive Benefits in the form of reimbursements for dental and vision expenses. If elected, the Benefit Option will be funded by Participant Contributions on a pre-tax Salary Reduction basis as provided in the Employer and Participant Contributions section in the Plan Document.

Unless an exception applies as described in the Irrevocability of Elections and Exceptions section, such election is irrevocable for the duration of the Period of Coverage to which it relates.

The **HSA Contribution Benefit** may be elected with the **Dental/Vision FSA**.

E.2 Benefit Contributions

The annual Contribution for a Participant's **Dental/Vision FSA** is equal to the annual Benefit amount elected by the Participant.

E.3 Eligible Dental and Vision Expenses

Under the **Dental/Vision FSA**, a Participant may receive reimbursement for dental and vision expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred**. A dental or vision expense is incurred at the time the dental or vision 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 care.

- **Dental and Vision Expenses**. Dental and Vision Expenses means expenses incurred by a Participant, the Participant's Spouse or Dependent(s) covered under the **Dental/Vision FSA** within the meaning of "health care" as defined in Code §213(d), provided, however, that such expense is for vision or dental care only. This term does not include expenses that are excluded under Appendix A to this Plan, nor any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through the Health Plan, other insurance, or any other accident or health plan. If only a portion of a Health Care Expense has been reimbursed elsewhere, then the **Dental/Vision FSA** can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Section.

- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the **Dental/Vision FSA**. Other expenses that are not reimbursable are listed in Appendix A to the Plan Document.

E.4 Maximum and Minimum Benefits

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum dollar amount elected by the Participant for reimbursement of Dental and Vision 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 **Dental/Vision FSA**. Notwithstanding the foregoing, no reimbursements will be available for Dental and Vision 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 Dental and Vision 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 Dollar Limit.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dental and Vision Expenses incurred in any Period of Coverage shall not exceed the maximum allowed under federal regulations and shall be the amount set forth in the annual open enrollment materials for the Plan Year. Reimbursements due for Dental and Vision Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's **Dental/Vision FSA**.

- **Changes**. For subsequent Plan Years, the maximum 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 his or her 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 **Dental/Vision FSA** 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 **Dental/Vision FSA**; reduced by

    - All reimbursements made during the entire Period of Coverage.

- **FMLA Leave.** Any change in an election for FMLA leave will change the maximum reimbursement benefits in accordance with FMLA or the regulations governing cafeteria plans.

- **Monthly Limits on Reimbursing OTC Drugs.** Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's **Dental/Vision FSA** in a single calendar month, even assuming that the drug otherwise meets the requirements of this Section, including that it is for dental or vision care under Code §213(d). Stockpiling is not permitted.

E.5 Establishment of Account

The Plan Administrator will establish and maintain a **Dental/Vision FSA** with respect to each Participant who has elected to participate in the **Dental/Vision FSA**, 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 **Dental/Vision FSA** 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 **Dental/Vision FSA** will be debited during each Period of Coverage for any reimbursement of Dental and Vision Expenses incurred during the Period of Coverage or during a Grace Period as provided below.

- **Available Amount Not Based on Credited Amount**. The amount available for reimbursement of Dental and Vision 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 **Dental/Vision FSA** at a particular point in time.

E.6 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 **Dental/Vision FSA** 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 Dental and Vision Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. 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. Claims must be submitted on or before the **Claims Filing Deadline**.

- **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 **Dental/Vision FSA** 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 Dental and Vision Expense was incurred shall be forfeited and applied as described above.

E.7 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, asfollows:

  - An individual may be reimbursed for Dental and Vision Expenses incurred during a Grace Period from amounts remaining in his or her **Dental/Vision FSA** Account at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year **Dental/Vision FSA** Amounts") if the individual is either:

    - A qualified beneficiary as defined under COBRA who has COBRA coverage under the **Dental/Vision FSA** Benefit Option on the last day of that Plan Year; or

    - A Participant with **Dental/Vision FSA** coverage that is in effect on the last day of that Plan Year. As a clarification: A participant who terminates coverage before the last day of the Plan Year will not be reimbursed for expenses incurred during the Grace Period associated with that Plan Year. A terminated participant may only be reimbursed for expenses incurred during the participant's period of coverage (Dental/Vision FSA participants' coverage ceases at the end of the month following the last contribution).

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

  - Dental and Vision Expenses incurred during a Grace Period and approved for reimbursement will be reimbursed first from any available Prior Plan Year **Dental/Vision FSA** Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year **Dental/Vision FSA** Amounts will be debited for any reimbursement of Dental and Vision Expenses incurred during the Grace Period that is made from such Prior Plan Year **Dental/Vision FSA** Amounts.

  - Claims for reimbursement of Dental and Vision Expenses incurred during a Grace Period must be submitted no later than the **Claims Filing Deadline** to which the Grace Period relates in order to be reimbursed from Prior Plan Year **Dental/Vision FSA** Amounts. Any Prior Plan Year **Dental/Vision FSA** 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.

E.8 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 Dental and Vision 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 limited scope Dental and Vision Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Plan Administrator by no later than the **Claims Filing Deadline**, setting forth:

  - The person or persons on whose behalf Dental and Vision Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - 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 Dental and Vision Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Section E.13 and applicable IRS guidance regarding electronic payment card programs.

- **Claims Denied**. For appeal of claims that are denied, see the Appeals Procedure in the Plan Document.

- **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.

E.9 Reimbursements After Termination; Limited COBRA Continuation

The Participant will not be able to receive reimbursements for Dental and Vision 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 Dental and Vision 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 Dental or Vision 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 **Dental/Vision FSA** because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the **Dental/Vision FSA** 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 **Dental/Vision FSA** 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 **Dental/Vision FSA** Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- 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 **Dental/Vision FSA** 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.

E.10 Qualified Reservist Distribution

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

- The Participant's Contributions to the **Dental/Vision FSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **Dental/Vision FSA** 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 **Dental/Vision FSA** equal to his or her Contributions to the **Dental/Vision FSA** 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 Dental and Vision 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 Dental and Vision 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 **Dental/Vision FSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **Dental/Vision FSA** 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 his or her gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

E.11 Named Fiduciary

The Plan Administrator is the Named Fiduciary for the **Dental/Vision FSA**.

E.12 Coordination of Benefits

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

E.13 Debit Cards

Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs. In addition, the following provisions shall apply:

- *Initial and Periodic Certification.* Before receiving an electronic payment card, a Participant must certify that he or she will only use the card to pay for Dental/Vision Care Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see below) for expenses paid with the card. The Participant must also agree to abide by any other the terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from Compensation and offsetting against other Dental/Vision FSA claims. The Participant must reaffirm these agreements during each subsequent Open Enrollment Period in order for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in deactivation of the card.
- *Deactivation of Card.* A Participant's card will be deactivated when participation in the Dental/Vision FSA ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures). A Participant whose card has been deactivated must request reimbursement for Dental/Vision Care Expenses through other methods (e.g., by submitting paper or online claims).
- *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Plan Administrator or its designee. The card's debit balance (or credit limit, as applicable) must be limited to the amount of the Participant's available reimbursement. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the Dental/Vision FSA is being made is a Dental/Vision Care Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.
- *Documentation.* For each expense that is paid with the card, the Participant must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to the Plan, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from the Plan must repay the Plan for the unsubstantiated expense. In addition, the Participant's card may be deactivated.
- *Correction of Improper Payments.* Participants must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance. If the Plan is unable to recoup an improper payment, the Employer will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

AUTHORITY: section 33.103, RSMo 2016. Original rule filed March 15, 1988, effective June 1, 1988. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 24, 2021, effective July 9, 2021, expires Jan. 1, 2022.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency is effective.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

PROCLAMATION

WHEREAS, on May 30, 2021, the General Assembly adjourned pursuant to Article III, Section 20(a) of the Missouri Constitution; and

WHEREAS, Sections 190.800 to 190.839 RSMo authorize the ground ambulance service reimbursement allowance; and

WHEREAS, Sections 198.401 to 198.439 RSMo authorize the nursing facility reimbursement allowance; and

WHEREAS, Sections 208.431 to 208.437 RSMo authorize the Medicaid managed care organization reimbursement allowance; and

WHEREAS, Sections 408.453 to 408.482 RSMo authorize the federal reimbursement allowance ("FRA"); and

WHEREAS, Sections 338.500 to 338.550 RSMo authorize the pharmacy tax; and

WHEREAS, Section 633.401 RSMo authorize the intermediate care facility for the intellectually disabled assessment; and

WHEREAS, such reimbursement allowances, taxes, and assessments are set to expire on September 30, 2021; and

WHEREAS, the General Assembly adjourned without extending the expiration date of such allowances, taxes, and assessments; and

WHEREAS, the calculation of state revenues for the Fiscal Year 2022 state operating budget included the provision of such allowances, taxes, and assessments to fund primary components of the MO HealthNet program; and

WHEREAS, the expiration of such allowances, taxes, and assessments will cost the State of Missouri approximately $591 million dollars in fiscal year 2022 and approximately $788 million dollars in fiscal year 2023; and

WHEREAS, the expiration of such allowances, taxes, and assessments will also result in reduced payments from the MO HealthNet program to healthcare providers in the amount of $1.53 billion dollars in fiscal year 2022 and $2 billion dollars in fiscal year 2023; and

WHEREAS, the expiration of such allowances, taxes, and assessments would also require the State of Missouri to institute immediate cost-savings measures, including rate decreases, elimination of non-mandatory MO HealthNet programs, and would result in additional fee schedule changes that would be detrimental to the citizens of the State of Missouri, and our healthcare providers; and

WHEREAS, these costs will significantly interfere with the provision of healthcare to Missourians and could cause disruptions in our state healthcare system.

NOW THEREFORE, on the extraordinary occasion that exists in the State of Missouri:

I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, pursuant to the authority vested in me as Governor by the Constitution of the State of Missouri, do, by this Proclamation, convene the One Hundred and First General Assembly of the State of Missouri in the First Extra Session of the First Regular Session; and

I HEREBY call upon the Senators and Representatives of said General Assembly to meet in the State Capitol in the City of Jefferson at the hour of 12:00 p.m. on Wednesday, June 23rd, 2021; and

I HEREBY state that the action of said General Assembly is deemed necessary concerning each matter specifically designated and limited hereinafter as follows:

1. To enact legislation amending Section 190.839 RSMo, in order to extend the expiration of the ground ambulance service reimbursement allowance at least three years beyond the expiration date of September 30, 2021;

2. To enact legislation amending Section 198.439 RSMo, in order to extend the expiration of the nursing facility reimbursement allowance at least three years beyond the expiration date of September 30, 2021;

3. To enact legislation amending Section 208.437 RSMo, in order to extend the expiration of the Medicaid managed care organization reimbursement allowance at least three years beyond the expiration date of September 30, 2021;

4. To enact legislation amending Section 208.480 RSMo, in order to extend the expiration of the FRA at least three years beyond the expiration date of September 30, 2021;

5. To enact legislation amending Section 338.550 RSMo, in order to extend the expiration of the pharmacy tax at least three years beyond the expiration date of September 30, 2021;

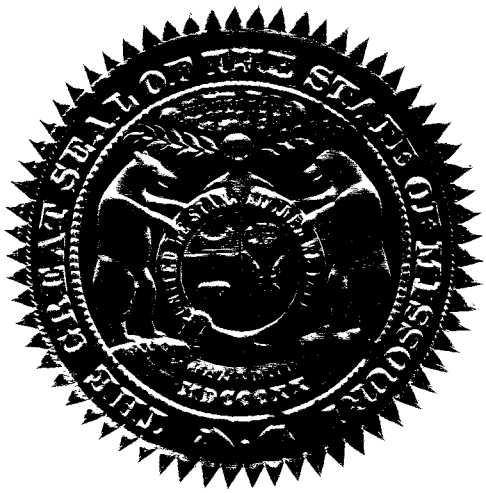
6. To enact legislation amending Section 633.401 RSMo, in order to extend the expiration of the intermediate care facility for the intellectually disabled assessment at least three years beyond the expiration date of September 30, 2021;

7. To enact legislation amending subdivision (12) of subsection 1 of Section 208.152 RSMo, to exclude "abortifacient drugs or devices" from family planning services, and to further define "abortifacient drugs or devices" to include the following when prescribed and intended for family planning: mifepristone in a regimen with or without misoprostol when used to induce an abortion; misoprostol alone when used to induce an abortion; levonorgestrel (Plan B) when used to induce an abortion; ulipristal acetate (ella) or other progesterone antagonists when used to induce an abortion; an intrauterine device (IUD) or a manual vacuum aspirator (MVA) when used to induce an abortion; or any other drug or device approved by the federal Food and Drug Administration that is intended to cause the destruction of an unborn child, as defined in section 188.015;

8. To enact legislation amending Section 208.659 RSMo, in order to exclude a provider from reimbursement under the uninsured women's health program if such provider is an abortion facility, as defined in section 188.015, or any affiliate or associate thereof;

9. To allow the Senate to consider appointments to boards, commissions, departments, and divisions that require the advice and consent of the Senate; and

10. Such additional and other matters as may be recommended by the Governor by special message to the General Assembly after it shall have been convened.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 22nd day of June, 2021.

MICHAEL L. PARSON
GOVERNOR

ATTEST:

JOHN R. ASHCROFT
SECRETARY OF STATE