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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JOHN R. ASHCROFT

SECRETARY OF STATE

MISSOURI REGISTER

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title		Division	Chapter	Rule
3	CSR	10-	4	.115
Department	*Code of State Regulations*	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is sos.mo.gov/adrules/csr/csr

The *Register* address is sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) business days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

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

EMERGENCY AMENDMENT

1 CSR 10-15.010 Cafeteria Plan. The commissioner is replacing the *Cafeteria Plan for the Employees of the State of Missouri* document referred to in section (2) with an updated version.

PURPOSE: This amendment makes changes to the benefits available to state and other public entity employees under the State of Missouri's cafeteria plan (the Plan).

EMERGENCY STATEMENT: This emergency amendment makes changes to the written Plan document maintained by the commissioner pursuant to section 33.103.3, RSMo, including renaming the Limited Scope Health Flexible Spending Account as the Dental/Vision Flexible Spending Account and adding a new section on the use of debit cards with such accounts. The emergency amendment must be effective January 1, 2021, when the new Plan year begins, to ensure the new Plan document is in effect at the start of the new Plan year and to comply with section 33.103.3, RSMo.

*The commissioner therefore finds that this emergency rule amendment is necessary to preserve a compelling governmental interest that requires an early effective date. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The commissioner believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment was filed December 16, 2020, becomes effective January 4, 2021, and expires July 2, 2021.*

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

Cafeteria Plan for the Employees of the State of Missouri

Plan Document

Effective January 1, 2021
(with an original effective date of January 1, 1992)

Cafeteria Plan
for the Employees of
the State of Missouri

Plan Document

Table of Contents

Section 1
Introduction

1.1 **Establishment of the Plan**

The State of Missouri (the "Employer") hereby amends and restates the State of Missouri Cafeteria Plan (the "Plan") effective January 1, 2021 (the "Effective Date"). The original Plan was effective January 1, 1992.

1.2 **Purpose of the Plan**

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

- **Premium Payment Plan (PPP)** to make pre-tax Salary Reduction Contributions to pay the Employee's share of the premium or contribution for the Health Plan, Dental Plan, and/or Vision Plan.

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

- **Dental/Vision Flexible Spending Account (Dental/Vision FSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of Dental and Vision Expenses.

- **Dependent Care Assistance Program (DCAP)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.

- **Health Savings Account Contribution Benefit (HSA Contribution Benefit)** to make pre-tax Salary Reduction Contributions to a Health Savings Account.

1.3 **Legal Status**

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

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

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

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

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

1.4 **Capitalized Terms**

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

Section 2
General Information

Name of the Cafeteria Plan	State of Missouri Cafeteria Plan
Name of Employer	State of Missouri
Address of Plan	Office of Administration, P.O. Box 809, Jefferson City, MO 65102-0809
Plan Administrator	State of Missouri/Office of Administration
Plan Sponsor and its IRS	State of Missouri/Office of Administration
Employer Identification Number	44-6000987
Named Fiduciary & Agent for Service of Legal Process	State of Missouri
Type of Administration	The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the State of Missouri Cafeteria Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. State of Missouri may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
Plan Number	501
Benefit Option Year	The twelve-month period ending December 31 (with an additional 2½ month grace period).
Plan Effective Date	January 1, 2021, with an original effective date of January 1, 1992
Claims Administrator	Application Software, Inc., dba ASI, dba ASIFlex
Plan Renewal Date	January 1
Internal Revenue Code and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.

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

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

Section 3
Benefit Options and Method of Funding

3.1 **Benefits Offered**

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

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

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

3.2 **Employer and Participant Contributions**

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

3.3 **Computing Salary Reduction Contributions**

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

- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the **PPP**, **Health FSA**, **Dental/Vision FSA**, or **DCAP,** as permitted under the Plan, the Salary Reductions will be, for the Benefits affected, calculated as follows:

  - An amount equal to:

    - The new annual amount elected pursuant to the Method of Timing and Elections section below;

    - Less the aggregate Contributions, if any, for the period prior to such election change;

    - Payable over the remaining term of the Period of Coverage commencing with the election change;

  - An amount otherwise agreed upon between the Employer and the Participant; or

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

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

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

- **After-Tax Contributions for PPP.** After-tax Contributions for the Health Plan will be paid outside of this Plan.

3.4 **Funding This Plan**

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

- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan

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

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

Section 4
Eligibility and Participation

4.1 **Eligibility to Participate**

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

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

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

4.2 **Required Salary Reduction Agreement**

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

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

4.3 **Termination of Participation**

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

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

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

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

4.4 **Rehired Employees**

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

4.5 **Eligibility Rules Regarding the Health FSA**

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

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

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

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

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

4.7 **FMLA Leaves Of Absence**

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

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

- With after-tax dollars, by sending monthly payments to the Employer's designee by the due date established by the Employer;

- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any; or

- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. Pre-tax dollars may not be used to fund coverage during the next Plan Year (notwithstanding the Grace Period provision). However, see Sections B.7, D.8, and E.7 for information regarding the Grace Period for participants who terminate coverage.

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

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

Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as **DCAP** Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

4.8 **Non-FMLA Leaves of Absence**

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

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

4.9 **Death**

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

4.10 **COBRA**

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

4.11 **USERRA**

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

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

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

- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

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

Section 5
Method of Timing and Elections

5.1 **Initial Election**

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

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

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

5.2 **Open Enrollment**

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

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

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

5.3 **Failure to Elect**

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

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or

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

Section 6
Irrevocability of Elections and Exceptions

6.1 **Irrevocability of Elections**

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

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

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

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

- **Timing for Making New Election if Exception to Irrevocability Applies**. A Participant may make a new election within 30 days of the occurrence of an event described in section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Health Plan shall automatically result in a corresponding election change, whether or not requested.

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

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

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

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

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

    - All reimbursements made during the entire Period of Coverage.

6.3 **Change in Status Defined**

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

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

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

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

    - A termination or commencement of employment;

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

    - A change in worksite; or

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

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

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

6.4 **Events Permitting Exception to Irrevocability Rule**

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

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

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

- **Termination of Employment**. A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.

- **Leave of Absence**. A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.

- **Change in Status**. *(Applies to the **PPP**, **Health FSA**, **Dental/Vision FSA**, and **DCAP** as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer, referred to as the general consistency requirement.

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

  The Plan Administrator, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

  - **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel health plan, dental plan, and/or vision plan coverage for:

    - The Spouse involved in the divorce, annulment, or legal separation;

    - The deceased Spouse or Dependent; or

    - The Dependent that ceased to satisfy the eligibility requirements.

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

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

  - **Gain of Coverage Eligibility under Another Employer's Plan.** When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage

under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

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

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

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

- **HIPAA Special Enrollment Rights** (*Applies to the **PPP** only*). If the Participant, the Participant's Spouse or Dependent is entitled to special enrollment rights under a group health plan as required by HIPAA, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds with such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:

  - The Participant, Spouse or Dependent declined to enroll in group health plan coverage because the Participant, the Participant's Spouse or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

  - The Participant acquired a new Dependent as a result of marriage, birth, adoption or placement for adoption; or

  - The Employee or Dependents who are eligible but did not enroll for coverage when initially eligible and:

    - The Employee or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or

    - The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

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

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

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

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

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

- **Medicare and Medicaid.** (*Applies to the **PPP**, **Health FSA**, **Dental/Vision** FSA, but does not apply to the **DCAP***). If a Participant, Spouse or Dependent is enrolled in a Benefit under this Plan and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Health Plan covering the person, and the **Health FSA** coverage may be cancelled but not reduced. However, such cancellation will not be effective to the extent that it would reduce future contributions to the **Health FSA** or the **Dental/Vision FSA** to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the **Health FSA** or the **Dental/Vision FSA** coverage.

- **Change in Cost.** *(Applies to the **PPP** and **DCAP** as limited below, but does not apply to the **Health FSA** or the **Dental/Vision FSA**).* For purposes of this Section, "similar coverage" means coverage for the same category of Benefits for the same individuals.

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

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

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

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

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

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

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

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

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

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

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

- **Change in Coverage.** (*Applies to the **PPP** and **DCAP**, but not to the **Health FSA** or the **Dental/Vision FSA***). The definition of "similar coverage" applied in the Change of Cost provision above also applies here.

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

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

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

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

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

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

  - Any other similar fundamental loss of coverage.

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

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

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

- **Loss of Coverage under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following:

  - A children's health insurance program (CHIP) under Title XXI of the Social Security Act;

  - A health care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization;

  - A state health benefits risk pool; or

  - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.

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

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

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

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

- **Enrollment in a Group Health Plan that Offers Minimal Essential Coverage or in a Health Care Exchange or Marketplace.** An Employee may make a **prospective** election change that is on account of and corresponds with a change to his/her PPP election, so long as:

  - The Employee's employment status changes from an expectation to work 30 hours or more per week to an expectation to work less than 30 hours per week (even if that change fails to make the Employee ineligible for Employer-sponsored group health plan coverage); AND the Employee enrolls in a group health plan that offers minimal essential coverage (as defined by the Affordable Care Act) with a new coverage effective date no later than the first day of the second month following the month that includes the date the original coverage is revoked; or

  - The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or the Employee seeks to enroll in a Marketplace during the Marketplace's annual open enrollment period; AND the Employee enrolls in the Marketplace with a new coverage effective date no later than the day immediately following the last day the original coverage is revoked.

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

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

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

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

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

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

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

6.6 **Election Modifications Required by Plan Administrator**

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

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

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

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

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

  In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 7
Claims and Appeals

7.1 **Claims under the Plan**

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

7.2 **Notice from ASI**

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

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

7.3 **First Level Appeal to ASI**

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

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

7.4 **ASI Action on Appeal**

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

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

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

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

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

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

7.6 **Plan Administrator Action on Appeal**

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

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

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

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

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

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

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

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

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

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

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

Section 8
Plan Administration

8.1 **Plan Administrator**

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

8.2 **Powers of the Plan Administrator**

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

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

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

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

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

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

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

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

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

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

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

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

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

8.4 **Outside Assistance**

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

8.5 **Insurance Contracts**

The Employer and/or some of the related employers adopting this Plan may have the right to enter into a contract with one or more insurance companies or self-fund for the purposes of providing any Benefits under the Plan; and to replace any of such insurance companies, contracts, or benefits. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer Contributions toward such insurance.

8.6 **Fiduciary Liability**

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

8.7 **Inability to Locate Payee**

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

8.8 **Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Participant's account, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, correct by making the appropriate adjustments of

such amounts as necessary to credit the Participant's account or such other person's account or withhold any amount due to the Plan or the Employer from Compensation paid by the Employer.

Section 9
Amendment or Termination of the Plan

9.1 **Permanency**

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

9.2 **Right to Amend**

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

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

9.3 **Right to Terminate**

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

Section 10
General Provisions

10.1 No Contract of Employment

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

10.2 Compliance with Federal Mandates

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

10.3 Verification

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

10.4 Limitation of Rights

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

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

10.5 Non-Assignability of Rights

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

10.6 Governing Law

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

10.7 **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.

10.8 **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.

10.9 **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.

10.10 **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.

10.11 **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.

Section 11
HIPAA Privacy and Security

11.1 Provision of Protected Health Information to Employer

For purposes of this Section, 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 **Health FSA** and the **Dental/Vision FSA**, 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 or as otherwise required or permitted by HIPAA.

11.2 Permitted Disclosure of Enrollment/Disenrollment Information

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

11.3 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.

11.4 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 functions 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).

11.5 **Conditions of Disclosure for Plan Administration Purposes**

Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, 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;
- 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 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 agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the 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 agrees 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.

11.6 **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, 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, 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 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

11.7 **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 under the section entitled *Conditions of Disclosure for Plan Administration Purposes*.

11.8 **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 Missouri Cafeteria Plan, State of Missouri has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 2020.

State of Missouri

By:_____

Its:_____

Attest:_____

Its:_____

Glossary

Capitalized terms used in the Plan have the following meanings:

Account means the account(s) maintained under this Cafeteria Plan by the Plan Administrator to which allocations of employer contributions are made for each participant as required by this Cafeteria Plan and from which payments, as permitted by this Cafeteria Plan, shall be paid.

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

Benefit Eligible Employee means an Employee eligible for a group health insurance plan sponsored by the Employer. A Benefit Eligible Employee is eligible to enroll in all of the benefit plans under this Plan, including the PPP, the Health FSA, the Dental/Vision FSA, and/or the DCAP. Eligibility for the different benefit plans under this Plan is also defined in Section 4.1.

Benefit Option means a qualified benefit under Code §125(f) that is offered under this Cafeteria Plan, or an option for coverage under an underlying accident or health plan.

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

Claims Administrator means Application Software, Inc., dba ASI, dba ASIFlex.

Claims Filing Deadline means the 15th of the fourth month following the end of the Plan Year in which the claims were incurred (i.e., April 15th immediately following the end of the Plan Year). All claims must be submitted by this deadline; any remaining funds that are unclaimed will be forfeited. The **Claims Filing Deadline** may be extended only at the discretion of the Plan Administrator; participants will be notified of any extension of the deadline on the Plan's website.

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 §132(f)(4) plan; and any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

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

DCAP means Dependent Care Assistance Program**.**

Dental and Vision Expenses has the meaning defined in the **Dental/Vision FSA** Schedule below (see Schedule E).

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

- For purposes of accident or health coverage (to the extent funded under the **PPP** and for purposes of the **Health FSA)**:

    - A dependent is defined as in Code §§105(b) and 152, determined without regard to §152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and

    - 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 **DCAP**, a dependent means a Qualifying Individual.

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

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

Dependent Care Assistance Program means the dependent care assistance program 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 **DCAP** Schedule below (see Schedule D).

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 **DCAP** established under Code §129; or any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

Effective Date of this Plan shall be January 1, 2021.

Employee means any person employed by the employer. An Employee is eligible to enroll in the DCAP. Eligibility for the different benefit plans under this Plan is also defined in Section 4.1.

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

- Leased employees (as defined by §414 (n) of the Code);

- Contract workers and independent contractors; and

- Individuals paid by a temporary or other employment or staffing agency.

Employer means State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri and Southeast Missouri State University.

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

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

Grace Period means a period of time as specified by the Employer in which qualified Medical Care Expenses and/or Dependent Care Expenses incurred during the period may be paid or reimbursed from benefits or contributions remaining unused at the end of the immediately preceding Plan year from each respective account. Such Grace Period shall not extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding Plan Year to which the Grace Period relates.

HDHP means High Deductible Health Plan.

Health Care Expenses has the meaning defined in the **Health FSA** Schedule below (see Schedule B).

Health Flexible Spending Account means the health 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.

Health FSA means Health Flexible Spending Account.

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

Health Savings Account means the savings account Benefit Option established by the Employer's designee under this Plan.

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

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

HSA means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

HSA Contribution Benefit means the election to allow an Employee to receive HSA Contributions on a pre-tax, Salary Reduction basis and such Employer Contributions are excludable from the HSA Employee's income.

HSA Employee means an Employee covered under a qualifying High Deductible Health Plan (HDHP) (as defined by IRC §223). In order to receive Employer **HSA Contribution Benefit**, the Employee must certify that he or she: cannot be claimed as another person's tax dependent; is not entitled to Medicare Benefits, and does not have any health coverage other than HDHP coverage.

Dental/Vision Flexible Spending Account means the limited scope health flexible spending account component established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for dental and vision expenses not reimbursed under other programs. This account is sometimes referred to as a Limited Scope Health Flexible Spending Account

Dental/Vision FSA means Dental/Vision Flexible Spending Account.

Office of Administration means the Office of Administration of the State of Missouri.

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.

Participant means a person who is an Employee and who is participating in this Plan in accordance with the provisions of the Eligibility and Participation Section. 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 **Health FSA** or **DCAP**.

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 the Eligibility and Participation Section; and for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Eligibility and Participation Section.

PHI means Protected Health Information.

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

Plan Administrator means the Office of Administration or its duly appointed designee to administer this Cafeteria Plan.

Plan Year means the twelve-month period ending December 31.

PPP means the Premium Payment Plan.

Premium Payment Plan means the Benefit Option in which an Employee can elect to participate and have Contributions for the employer-sponsored Health Plan, Dental Plan, or Vision Plan paid on a pre-tax basis.

Protected Health Information (PHI) means information that is created or received by State of Missouri Cafeteria 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, as defined in ERISA §609(a).

Qualifying Dependent Care Services has the meaning described in the **DCAP** Schedule below (see Schedule D).

Qualifying Individual means:

- 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, 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 §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §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 Missouri that, under Code §414(b), (c), or (m), is treated as a single employer with State of Missouri for purposes of Code §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, forms and/or internet web site 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. Notwithstanding the above, for purposes of the **DCAP**, 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.

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

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

Waive coverage means to formally opt-out of participation in the **PPP** in writing or online.

Appendix A
Exclusions—Medical Expenses That Are Not Reimbursable From the Health FSA and the Dental/Vision FSA

The Plan Document contains the general rules governing what expenses are reimbursable under the **Health FSA** and the **Dental/Vision FSA**. This Appendix A, as referenced in the Plan Document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the **Health FSA** and the **Dental/Vision FSA** -- that is, expenses that are *not* reimbursable, even if such expenses meet the definition of "medical care" under Code §213(d) and may otherwise be reimbursable under the regulations governing health flexible spending accounts:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for Benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code §213(d) other than the exception outlined in Code §106(f) as related to menstrual care products.

- Any item that is not reimbursable under Code §§213(d) and 106(f) due to the rules in Prop. Treas. Reg. §1.125-2, Q-7(b)(4) or other applicable regulations.

Appendix B
Related Employers That Have Adopted This Plan

With the Approval of State of Missouri.

The following Related Employers have adopted this plan:

- The Office of Administration
- The Department of Agriculture
- The Department of Conservation
- The Department of Corrections
- The Department of Economic Development
- The Department of Elementary and Secondary Education
- The Department of Health and Senior Services
- The Department of Higher Education
- The Department of Insurance, Financial Institutions and Professional Registration
- The Department of Labor and Industrial Relations
- The Department of Mental Health
- The Department of Natural Resources
- The Department of Public Safety
- The Department of Revenue
- The Department of Social Services
- The Department of Transportation
- The Office of the Attorney General
- The Office of the Governor
- The Office of the Lieutenant Governor
- The Office of the State Auditor
- The Office of the Secretary of State
- The Office of the Treasurer
- The Missouri House of Representatives
- The Missouri Senate
- The Missouri Consolidated Health Care Plan
- The Missouri State Employees' Retirement System
- The Supreme Court
- Harris-Stowe State University Board of Regents
- Lincoln University Board of Curators
- Missouri State University
- Northwest Missouri State University Board of Regents
- Truman State University Board of Governors
- University of Central Missouri Board of Governors

Employer means State of Missouri including any agency, or department of the State of Missouri other than the University of Missouri, Southeast Missouri State University, Missouri Western University, and Missouri Southern State University.

Schedule A
Premium Payment Plan

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

A.1 Benefits

If the Employee is an enrolled participant in the Health Plan, Dental Plan, and/or Vision Plan and timely submits an executed Salary Reduction Agreement, the Employee can either:

- Option A: Elect Benefits under the **PPP** by electing to contribute his or her share for the Health Plan on a pre-tax basis; or

- Option B: Elect no Benefits under the **PPP** and to contribute his or her share, if any, for the Health Plan with after-tax deductions outside of this Plan.

If the Employee is an enrolled participant in the Health Plan, Dental Plan, and/or Vision Plan and does not timely submit an executed Salary Reduction Agreement, the Employee will be deemed to have elected Option A.

Benefits elected under Option A will be funded by the Participant's Contributions as provided in the Eligibility and Participation section in the Plan Document.

To determine when a Salary Reduction Agreement will be considered timely submitted, see the Method and Timing of Elections section in the Plan Document.

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

A.2 Benefit Contributions

The annual Contribution for the **PPP** is equal to the amount as set by the Employer, which may or may not be the same amount charged under the Health Plan, Dental Plan, and/or Vision Plan.

A.3 Medical Benefits Provided Under the Health Plan, Dental Plan, or Vision Plan

Medical benefits will be provided by the applicable Health Plan, Dental Plan, or Vision Plan, not this Plan. The types and amounts of medical benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the Health Plan, Dental Plan and/or Vision Plan are set forth in the documents relating to that plan. No changes can be made under this Plan with respect to such Health Plan, Dental Plan, or Vision Plan if such changes are not permitted under the applicable Health Plan, Dental Plan, or Vision Plan.

All claims to receive benefits under the Health Plan, Dental Plan, or Vision Plan shall be subject to and governed by the terms and conditions of the applicable Health Plan, Dental Plan, or Vision Plan and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

A.4 COBRA

To the extent required by COBRA, the Participant, Spouse and Dependent, as applicable, whose coverage terminates under the Health Plan, Dental Plan, and/or Vision Plan because of a COBRA qualifying event and who is a qualified beneficiary as defined under COBRA, shall be given the opportunity to continue the same coverage that the Participant, Spouse or Dependent had under the Health Plan, Dental Plan, and/or Vision Plan the day before the qualifying event for the periods prescribed by COBRA, on a self-pay basis. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Schedule B
Health 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 to which this Schedule is attached.

B.1 Benefits

ABenefit Eligible Employee not enrolled in the **HSA Contribution Benefit**, can elect to participate in the **Health FSA** 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 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** cannot be elected with the **Health FSA**. In addition, a Participant who has an election for the **Health FSA** that is in effect on the last day of a Plan Year cannot elect the **HSA Contribution Benefit** for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's **Health FSA** is $0 as of the last day of that Plan Year. For this purpose, a Participant's **Health FSA** balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

B.2 Benefit Contributions

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

B.3 Eligible Health Care Expenses

Under the **Health FSA**, 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 **Health FSA** for medical care, as defined in Code §§213(d) and 106(f), 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 **Health FSA**. Other expenses that are not reimbursable are listed in Appendix A to the Plan Document.

B.4 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 **Health FSA**. 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 Dollar Limit.** The maximum 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 not exceed the maximum allowed under federal regulations and shall be the amount as set forth in annual open enrollment materials for the Plan Year. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's **Health 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 **Health 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 **Health 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 **Health FSA** in a single calendar month, even assuming that the drug otherwise meets the requirements of this Section, including that it is for medical care under Code §213(d). Stockpiling is not permitted.

B.5 Establishment of Account

The Plan Administrator will establish and maintain a **Health FSA** with respect to each Participant who has elected to participate in the **Health 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 **Health 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 **Health FSA** 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 as provided 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 **Health FSA** at a particular point in time.

B.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 **Health 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 Health Care 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 **Health 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 Health Care Expense was incurred shall be forfeited and applied as described above.

B.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, as follows:

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

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

    - A Participant with **Health 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 (Health FSA participants' coverage ceases at the end of the month following the last contribution).

  - 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.

  - Prior Plan Year **Health FSA** Amounts may not be cashed out or converted to any other taxable or non-taxable Benefit Option. For example, Prior Plan Year **Health FSA** 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 **Health 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 **Health FSA** Amounts will be debited for any reimbursement of Health Care Expenses incurred during the Grace Period that is made from such Prior Plan Year **Health FSA** Amounts.

  - Claims for reimbursement of Health Care 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 **Health FSA** Amounts. Any Prior Plan Year **Health 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.

B.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 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 **Claims Filing Deadline**, setting forth:

    - The person or persons on whose behalf Health Care 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 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 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 B.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.

B.9 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 **Health FSA** because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the **Health 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 **Health 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 **Health 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 **Health 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.

B.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 **Health FSA**:

- The Participant's Contributions to the **Health FSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **Health 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 **Health FSA** equal to his or her Contributions to the **Health 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 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 **Health FSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **Health 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.

B.11 Named Fiduciary

The Plan Administrator is the Named Fiduciary for the **Health FSA**.

B.12 Coordination of Benefits

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

B.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 Medical 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 Health 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 Health 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 Medical 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 Health FSA is being made is a Medical 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.

Schedule C
HSA Contribution Benefit

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

C.1 HSA Tax Advantages

An Employee eligible to participate in the HSA may elect to participate in the **HSA Contribution Benefit** by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's Health Savings Account (HSA) established and maintained outside the Plan by a trustee/custodian to which the Employer can forward Contributions to be deposited. This funding feature constitutes the **HSA Contribution Benefit**.

As described more fully herein, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

C.2 Establishing an HSA

For administrative convenience, the Employer may choose to make Contributions for Employees to HSAs established at a bank selected by the Employer or limit the number of HSA providers to whom it will forward Contributions-such a list is not an endorsement of any HSA provider. The selected bank will be an authorized HSA trustee. The forms necessary to establish an HSA at the selected bank will be provided to Participants. Participants are responsible for managing their own **HSA**, including choosing how **HSA** funds are invested and following the rules of the selected bank and the IRS. Once the Employer Contributions have been deposited in a Participant's **HSA Contribution Benefit**, the Participant has a non-forfeitable interest in the funds and is free to request a distribution of the funds or to move them to another **HSA** provider, to the extent permitted by law.

The HSA Contribution Benefit cannot be elected with the **Health FSA**. In addition, a Participant who has an election for the **Health FSA** that is in effect on the last day of a Plan Year cannot elect the **HSA Contribution Benefit** for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's **Health FSA** is $0 as of the last day of the Plan Year. For this purpose, a Participant's **Health FSA** balance is determined on a cash basis -- that is, without regard to claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

C.3 Certification of HSA Contribution Benefit Eligibility

To be eligible for the **HSA Contribution Benefit**, an HSA Employee must certify to the Employer that he or she is eligible for an HSA contribution and does not have any non-HDHP coverage. A married Participant must also certify that his or her Spouse does not have any non-HDHP coverage. A Participant is required to notify the Employer immediately if there are any changes in the information contained in the certification. Failure to provide accurate and updated information could cause the **HSA Contribution Benefit** to be included in a Participant's gross income and may also be subject to excise tax.

C.4 Maximum Contribution

The annual Contribution for a Participant's **HSA Contribution Benefit** is equal to the annual Benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's HDHP coverage option for the calendar year in which the Contribution is made (the maximum contribution for each Plan Year is set forth in the annual open enrollment materials).

Participants age 55 or older may make an additional catch-up Contribution of $1,000 per year.

In addition, the maximum annual Contribution shall be:

- Reduced by any matching or other Employer Contribution made on the Participant's behalf; and
- Prorated for the number of months in which the Participant is an HSA Eligible Individual.

C.5 Recording Contributions for HSA

The Plan Administrator will maintain records to keep track of Contributions an Employee makes via pre-tax Salary Reductions to his or her HSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

C.6 Distributions from HSA Contribution Benefit

Distribution from an **HSA Contribution Benefit** will be tax-free if the distribution is for expenses incurred for a Participant's health care as defined in IRC §213(d) or the health care of a Participant's legal Spouse or tax Dependents. Expenses must have been incurred after the establishment of the **HSA Contribution Benefit** to be tax-free. **HSA Contribution Benefit** distributions used to pay insurance premiums will not be tax-free unless they are used for COBRA coverage, qualified long-term care insurance, health insurance maintained while the individual is receiving unemployment compensation under federal or state law, or health insurance for an individual age 65 or over, other than a Medicare supplemental policy.

C.7 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA is governed by Code §223.

C.8 Reporting Issues

Each Participant will be responsible for reporting Contributions made to his or her **HSA Contribution Benefit** and for reporting distributions from the HSA. A Participant is also responsible for reporting whether or not HSA distributions were used for qualified health expenses or whether the distributions were taxable. A Participant should maintain records sufficient to demonstrate whether or not distributions were taxable.

C.9 Voluntary Participation

Participation in the **HSA Contribution Benefit** is entirely voluntary and may be terminated at any time by notifying the Employer. Although the Employer expects to continue this **HSA Contribution Benefit** indefinitely, it has the right to amend or terminate **HSA Contribution Benefit** at any time and for any

reason. It is also possible that changes to the program will be necessary or advisable as a result of future changes in state or federal tax laws.

C.10 HSA Not Intended to be an ERISA Plan

The **HSA Contribution Benefit** under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and Benefits will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

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

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 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 §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)(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 §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.

- **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, as follows:

  - 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 [Supp. 2013] **2016**. Original rule filed March 15, 1988, effective June 1, 1988. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 16, 2020, effective Jan. 4, 2021, expires July 2, 2021. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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.

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2150—State Board of Registration for the Healing Arts
Chapter 5—General Rules

EMERGENCY AMENDMENT

20 CSR 2150-5.025 Administration of Vaccines Per Protocol. The board is amending sections (1), (4) and (5) of the rule and adding section (8).

PURPOSE: This emergency amendment would allow pharmacy technicians to administer vaccines authorized by section 338.010, RSMo, by protocol, under the supervision of a Missouri-licensed pharmacist.

*EMERGENCY STATEMENT: On January 31, 2020, the U.S. Department of Health and Human Services (HHS) declared a public health emergency in response to the nationwide COVID-19 pandemic. The Governor of Missouri declared a similar State of Emergency on March 13, 2020, finding that COVID-19 poses a serious health risk for Missouri residents. Because of the COVID-19 pandemic, the U.S. Centers for Disease Control and Prevention (CDC) issued a public advisory indicating that "reducing the spread of respiratory illnesses, like flu, this fall and winter is more important than ever." The CDC recommended that eligible individuals protect themselves by getting a flu vaccine as promptly as possible. Missouri pharmacies have subsequently reported a significant increase in vaccine demand. In November 2020, multiple major chain pharmacies and independent pharmacies asked the Board of Pharmacy for immediate authorization to utilize pharmacy technicians to assist with immunizations. Simultaneously, multiple Missouri pharmacies have entered agreements with the federal government to administer the COVID-19 vaccine statewide which will exponentially increase the demand on Missouri pharmacists and pharmacy staff. The proposed emergency amendment would allow pharmacists to delegate administration of vaccines authorized by section 338.010 by protocol to properly trained Missouri pharmacy technicians, under the supervision of a qualified Missouri-licensed pharmacist. The emergency amendment would also provide increased flexibility for pharmacists immunizing outside of a pharmacy (e.g., a public health clinic, state/federal vaccination site). Absent an emergency amendment, Missouri pharmacies will be unable to meet vaccine demands for both the COVID-19 vaccine and vaccines authorized by section 338.010, which will detrimentally impact the public safety, health and welfare of Missouri citizens. This emergency amendment is particularly necessary given many healthcare providers are closed or limiting services due to COVID-19. As recognized by HHS, "nearly 90 percent of Americans live within five miles of a community pharmacy" and "pharmacies often offer extended hours and added convenience." Notably, HHS issued a similar emergency declaration on October 20, 2020, authorizing pharmacy technicians to administer COVID-19 and other childhood vaccines under the supervision of a pharmacist. As a result, the State Board of Registration for the Healing Arts finds there is an immediate danger to the public health, safety, and/or welfare and a compelling governmental interest that requires this emergency action. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The State Board of Registration for the Healing Arts believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment was filed January 4, 2021, becomes effective January 19, 2021, and expires July 17, 2021.*

(1) A pharmacist may administer vaccines authorized by Chapter 338, RSMo, pursuant to a written protocol with a Missouri licensed physician who is actively engaged in the practice of medicine. Unless otherwise restricted by the governing protocol, vaccines may be administered at any Missouri licensed pharmacy or at any non-pharmacy location identified in the governing protocol.

(A) Vaccines must be administered in accordance with treatment guidelines established by the Centers for Disease Control (CDC) and the manufacturer's guidelines, provided CDC guidelines shall control in the event of a conflict. Vaccines may not be administered to persons under *[twelve 12)]* **seven (7)** years of age unless otherwise authorized by law.

(B) Pharmacists shall ensure compliance with all state and federal laws and regulations pertaining to Vaccine Information Statements and informed consent requirements.

(C) Vaccines must be stored in accordance with CDC guidelines/recommendations and within the manufacturer's labeled requirements, including, when vaccinating outside of a pharmacy.

(D) A pharmacist may only delegate vaccine administration to an intern pharmacist **or qualified pharmacy technician** who has met the qualifications of subsections (3)(B) and (C) of this rule and is working under the direct supervision of a pharmacist qualified to administer vaccines. Proof of an intern's **or qualified pharmacy technician's** compliance with subsections (3)(B) and (C) must be maintained by both the supervising pharmacist and the intern pharmacist/**qualifying pharmacy technician** for a minimum of two (2) years.

(E) For purposes of this rule, a "qualified pharmacy technician" is defined as a currently registered Missouri pharmacy technician who:

1. Holds an active pharmacy technician certification issued by a certification entity accredited by the National Commission for Certifying Agencies,

2. Has an initial and, if applicable, annual documented assessment of competency in vaccine administration; and

3. Has assisted in the practice of pharmacy as a registered pharmacy technician in the state of Missouri for a minimum of one (1) year.

(4) Protocol Requirements.

(A) In addition to filing a NOI, pharmacists administering vaccines under this rule must first enter into a written protocol with a Missouri licensed physician. The written protocol may be valid for a time period not to exceed one (1) year. The protocol must be renewed annually and include the following:

1. The identity of the participating pharmacist and physician;
2. Time period of the protocol;
3. Authorized vaccines;
4. The patient or groups of patients authorized for vaccination;
5. Allowed routes and anatomic sites of administration;
6. If applicable, authorization to create a prescription for each administration under the physician's name;
7. Emergency response procedures, including, but not limited

to, procedures for handling/addressing adverse reactions, anaphylactic reactions, and accidental needle sticks;

8. The length of time the pharmacist must observe an individual for adverse events following an injection;

9. Procedures for disposing of used and contaminated supplies;

10. *[The street addresses of any non-pharmacy locations at which the pharmacist may administer vaccines]* **Authorization to administer vaccines at a non-pharmacy location, if applicable**;

11. Record-keeping requirements and any required notification procedures; and

12. A provision allowing termination of the protocol at any time at the request of any party.

(5) Record Keeping.

(A) The pharmacist shall ensure a record is maintained for each vaccine administered by protocol that includes:

1. The patient's name, address, and date of birth;

2. The date, route, and anatomic site of the administration;

3. The vaccine's name, dose, manufacturer, lot number, and expiration date;

4. The name and address of the patient's primary health care provider, as provided by the patient;

5. The identity of the administering pharmacist or, if applicable, the identity of the administering intern pharmacist **or qualified pharmacy technician** and supervising pharmacist; and

6. The nature of any adverse reaction and who was notified, if applicable.

(8) A qualified pharmacy technician immunizing pursuant to this rule must be supervised by a Missouri-licensed pharmacist who is authorized to immunize by protocol and who is physically present on-site when the vaccine is administered.

*AUTHORITY: section 334.125, **RSMo 2016, and sections** 338.010[,] and 338.220, RSMo [2016] **Supp. 2020**. Emergency rule filed Oct. 24, 2007, effective Nov. 3, 2007, expired April 30, 2008. Original rule filed Oct. 24, 2007, effective May 30, 2008. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Jan. 4, 2021, effective Jan. 19, 2021, expires July 17, 2021. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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.

Title 20—DEPARTMENT OF COMMERCE AND INSURANCE
Division 2220—State Board of Pharmacy
Chapter 6—Pharmaceutical Care Standards

EMERGENCY AMENDMENT

20 CSR 2220-6.050 Administration of Vaccines Per Protocol. The board is amending sections (1), (4) and (5) of the rule and adding section (8).

PURPOSE: This emergency amendment would allow pharmacy technicians to administer vaccines authorized by section 338.010, RSMo, by protocol, under the supervision of a Missouri-licensed pharmacist.

*EMERGENCY STATEMENT: On January 31, 2020, the U.S. Department of Health and Human Services (HHS) declared a public health emergency in response to the nationwide COVID-19 pandemic. The Governor of Missouri declared a similar State of Emergency on March 13, 2020, finding that COVID-19 poses a serious health risk for Missouri residents. Because of the COVID-19 pandemic, the U.S. Centers for Disease Control and Prevention (CDC) issued a public advisory indicating that "reducing the spread of respiratory illnesses, like flu, this fall and winter is more important than ever." The CDC recommended that eligible individuals protect themselves by getting a flu vaccine as promptly as possible. Missouri pharmacies have subsequently reported a significant increase in vaccine demand. In November 2020, multiple major chain pharmacies and independent pharmacies asked the board for immediate authorization to utilize pharmacy technicians to assist with immunizations. Simultaneously, multiple Missouri pharmacies have entered agreements with the federal government to administer the COVID-19 vaccine statewide which will exponentially increase the demand on Missouri pharmacists and pharmacy staff. The proposed emergency amendment would allow pharmacists to delegate administration of vaccines authorized by section 338.010 by protocol to properly trained Missouri pharmacy technicians, under the supervision of a qualified Missouri-licensed pharmacist. The emergency amendment would also provide increased flexibility for pharmacists immunizing outside of a pharmacy (e.g., a public health clinic, state/federal vaccination site). Absent an emergency amendment, Missouri pharmacies will be unable to meet vaccine demands for both the COVID-19 vaccine and vaccines authorized by section 338.010, which will detrimentally impact the public safety, health and welfare of Missouri citizens. This emergency amendment is particularly necessary given many healthcare providers are closed or limiting services due to COVID-19. As recognized by HHS, "nearly 90 percent of Americans live within five miles of a community pharmacy" and "pharmacies often offer extended hours and added convenience." Notably, HHS issued a similar emergency Declaration on October 20, 2020, authorizing pharmacy technicians to administer COVID-19 and other childhood vaccines under the supervision of a pharmacist. As a result, the Missouri State Board of Pharmacy finds there is an immediate danger to the public health, safety, and/or welfare and a compelling governmental interest that requires this emergency action. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The Missouri State Board of Pharmacy believes this emergency amendment is fair to all interested persons and parties under the circumstances. A proposed amendment, which covers this same material, is published in this issue of the **Missouri Register**. This emergency amendment was filed January 4, 2021, becomes effective January 19, 2021, and expires July 17, 2021.*

(1) A pharmacist may administer vaccines authorized by Chapter 338, RSMo, pursuant to a written protocol with a Missouri licensed physician who is actively engaged in the practice of medicine. Unless otherwise restricted by the governing protocol, vaccines may be administered at any Missouri licensed pharmacy or at any non-pharmacy location identified in the governing protocol.

(A) Vaccines must be administered in accordance with treatment guidelines established by the Centers for Disease Control (CDC) and the manufacturer's guidelines, provided CDC guidelines shall control in the event of a conflict. Vaccines may not be administered to persons under *[twelve (12)]* **seven (7)** years of age unless otherwise authorized by law.

(B) Pharmacists shall ensure compliance with all state and federal laws and regulations pertaining to Vaccine Information Statements and informed consent requirements.

(D) A pharmacist may only delegate vaccine administration to an intern pharmacist **or qualified pharmacy technician** who has met the qualifications of subsections (3)(B) and (C) of this rule and is working under the direct supervision of a pharmacist qualified to administer vaccines. Proof of an intern's **or qualified pharmacy**

technician's compliance with subsections (3)(B) and (C) must be maintained by both the supervising pharmacist and the intern pharmacist/**qualifying pharmacy technician** for a minimum of two (2) years.

(E) For purposes of this rule, a "qualified pharmacy technician" is defined as a currently registered Missouri pharmacy technician who:

1. Holds an active pharmacy technician certification issued by a certification entity accredited by the National Commission for Certifying Agencies,

2. Has an initial and, if applicable, annual documented assessment of competency in vaccine administration; and

3. Has assisted in the practice of pharmacy as a registered pharmacy technician in the state of Missouri for a minimum of one (1) year.

(4) Protocol Requirements.

(A) In addition to filing a NOI, pharmacists administering vaccines under this rule must first enter into a written protocol with a Missouri licensed physician. The written protocol may be valid for a time period not to exceed one (1) year. The protocol must be renewed annually and include the following:

1. The identity of the participating pharmacist and physician;
2. Time period of the protocol;
3. Authorized vaccines;
4. The patient or groups of patients authorized for vaccination;
5. Allowed routes and anatomic sites of administration;
6. If applicable, authorization to create a prescription for each administration under the physician's name;
7. Emergency response procedures, including, but not limited to, procedures for handling/addressing adverse reactions, anaphylactic reactions, and accidental needle sticks;
8. The length of time the pharmacist must observe an individual for adverse events following an injection;
9. Procedures for disposing of used and contaminated supplies;
10. *[The street addresses of any non-pharmacy locations at which the pharmacist may administer vaccines]* **Authorization to administer vaccines at a non-pharmacy location, if applicable**;
11. Record-keeping requirements and any required notification procedures; and
12. A provision allowing termination of the protocol at any time at the request of any party.

(5) Record Keeping.

(A) The pharmacist shall ensure a record is maintained for each vaccine administered by protocol that includes:

1. The patient's name, address, and date of birth;
2. The date, route, and anatomic site of the administration;
3. The vaccine's name, dose, manufacturer, lot number, and expiration date;
4. The name and address of the patient's primary health care provider, as provided by the patient;
5. The identity of the administering pharmacist or, if applicable, the identity of the administering intern pharmacist **or qualified pharmacy technician** and supervising pharmacist; and
6. The nature of any adverse reaction and who was notified, if applicable.

(8) A qualified pharmacy technician immunizing pursuant to this rule must be supervised by a Missouri-licensed pharmacist who is authorized to immunize by protocol and who is physically present on-site when the vaccine is administered.

AUTHORITY: sections ***338.010,*** *338.140,* ***and*** *338.220, [RSMo 2016, and section 338.010,] RSMo Supp. [2017]* ***2020****. Emergency rule filed Oct. 24, 2007, effective Nov. 3, 2007, expired April 30, 2008. Original rule filed Oct. 24, 2007, effective May 30, 2008. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Jan. 4, 2021, effective Jan. 19, 2021, expires July 17, 2021. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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