

**ARTICLE I
INTRODUCTION**

1.1 ESTABLISHMENT OF PLAN

State of Arizona (the "Employer") hereby establishes the State of Arizona Flexible Spending Accounts (the "Plan") effective October 1, 2007 (the "Effective Date").

1.2 PURPOSE OF THE PLAN

This Plan is designed to receive pre-tax Salary Reduction contributions to an account(s) for reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

1.3 LEGAL STATUS

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

The Health Care Flexible Spending Plan is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Medical Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The Dependent Care Flexible Spending Plan 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).

Although reprinted within this document, the Health Care Flexible Spending Plan and the Dependent Care Flexible Spending Plan are separate plans for purposes of administration, and all reporting and nondiscrimination requirements imposed by Code §§105 and 129.

**ARTICLE II
GENERAL INFORMATION**

NAME OF THE PLAN	State of Arizona Flexible Spending Accounts
NAME OF EMPLOYER	State of Arizona
PLAN ADMINISTRATOR	State of Arizona
NAMED FIDUCIARY & AGENT FOR SERVICE OF LEGAL PROCESS	State of Arizona
TYPE OF ADMINISTRATION	The Plan is administered by the Administrator with benefits provided in accordance with the provisions of the State of Arizona Flexible Spending Accounts. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. State of Arizona may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
BENEFIT PLAN YEAR	The twelve-month period between October 1 and September 30 of the following calendar year.
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 Administrator shall perform its duties as the 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 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 interpretation of the terms of any Plan document and any determination of fact adopted by the 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 Administrator shall be based only on such evidence presented to or considered by the 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 Administrator makes in its sole decision and further constitutes agreement to the limited standard and scope of review described by this section.

ARTICLE III
BENEFITS OFFERED AND METHOD OF FUNDING

3.1 BENEFITS OFFERED

Each Eligible Employee may elect one or more of the following Employer sponsored Benefits:

- Health Care Flexible Spending Plan;
- Dependent Care Flexible Spending Plan; or
- Receive his or her entire compensation in cash.

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

3.2 EMPLOYER AND PARTICIPANT CONTRIBUTIONS

- (a) **Employer Contributions.** There are no Employer contributions for the Health Care Flexible Spending Plan or the Dependent Care Flexible Spending Plan.
- (b) **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis or with after-tax deductions (as elected by the Participant and permitted under the Plan), an amount equal to the contributions required from the Participant for the Benefits elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation, whether on a pre-tax Salary Reduction basis or with after-tax deductions, shall be applied to fund Benefits as soon as administratively feasible. The maximum amount of Salary Reductions (or after-tax deductions, as applicable) shall not exceed the aggregate cost of the Benefits elected. Participants who elect any of the Benefits may pay for their required contributions, if any, on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Agreement.

3.3 COMPUTING SALARY REDUCTION CONTRIBUTIONS

- (a) **Salary Reductions per Pay Period.** The Salary Reduction for a pay period for a Participant is an amount equal to the annual premium for such Benefits divided by the number of pay periods in the Period of Coverage, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by the Administrator.

If a Participant increases his or her election under the Health Care Flexible Spending Plan or Dependent Care Flexible Spending Plan as permitted under Section 8.4, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to the new annual amount elected pursuant to Section 8.4, less the aggregate premiums (if any) for the period prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change, or an amount otherwise agreed upon between the Employer and the Participant, or an amount deemed appropriate by the Administrator.

- (b) **Considered Employer Contributions for Certain Purposes.** Salary Reductions that the Employer will apply to pay for the Participant's share of the premiums for benefits elected for the purposes of this Plan and the Code are considered Employer contributions.

- (c) **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, and a Participant's year-to-date Salary Reductions exceeded or are less than the required contributions necessary for benefits up to the date of termination, then the Employer will, if applicable, either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.

3.4 FUNDING THIS PLAN

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 or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, no Participant or 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 an unrelated third party paying agent to make Benefit payments on its behalf. The maximum contributions that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for the Health Care Flexible Spending Plan and the Dependent Care Flexible Spending Plan.

**ARTICLE IV
ELIGIBILITY AND PARTICIPATION**

4.1 ELIGIBILITY TO PARTICIPATE

An individual is eligible to participate in this Plan if the individual is an Employee who is regularly scheduled to work 20.0 hours or more per week.

The following classes of employees cannot participate in the State of Arizona Flexible Spending Accounts:

- Leased employees (as defined by § 414 (n) of the Code);
- Contract workers and independent contractors;
- Temporary employees and casual employees (Employees hired short-term to meet specific needs of the Employer); and
- Individuals paid by a temporary or other employment or staffing agency.

To begin the Salary Deferral on a pre-tax basis and enroll in the State of Arizona Flexible Spending Accounts, an eligible Participant must complete, sign and return to the Administrator or its designee a Benefit Election Agreement and/or a Salary Reduction Agreement by the deadline designated by the Plan Administrator. If an eligible Participant fails to return a Benefit Election Agreement and/or Salary Reduction Agreement such Participant is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the eligible Participant experiences an event permitting an election change mid-year.

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

4.2 TERMINATION OF PARTICIPATION

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

- (a) 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);
- (b) The termination of this Plan; or
- (c) The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year).

The 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.

Termination of participation in this Plan will automatically revoke the Participant's participation in both the Health Care Flexible Spending Plan and the Dependent Care Flexible Spending Plan.

4.3 PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

If a Participant separates from service 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 a 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.

4.4 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 the FMLA, the Employer will continue to maintain the Participant's Health Care Flexible Spending Benefits on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid FMLA leave, a Participant may elect to continue his or her Health Care Flexible Spending Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the premium with after-tax dollars, by sending monthly payments to the Employer 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, including unused sick days and vacation days), or by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the premium, 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).

Coverage under a Participant's Health Care Flexible Spending Account will terminate if premium payments are not received by the due date established by the Employer. If a Participant's Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverage ceases while on FMLA leave for any reason (including for non-payment of premiums), the Participant will be entitled to re-enter the Health Care Flexible Spending Plan or the Dependent Care Flexible Spending Plan 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 FMLA. A Participant whose coverage under the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account ceased will be entitled to elect whether to be reinstated in the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account 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 premiums. 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 Health Care Flexible Spending Account

premiums or his or her Dependent Care Flexible Spending Account premiums will be equal to the amount withheld prior to the period of FMLA leave.

4.5 NON-FMLA LEAVES OF ABSENCES

If a Participant goes on an unpaid leave of absence that does not affect Eligibility, then the Participant will continue to participate and the premiums 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 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.

4.6 SPECIAL RULE CONCERNING DEATH

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

4.7 COBRA

Under the COBRA rules as discussed in Section 6.8, the Participant's Spouse and Dependent(s) may be able to continue to participate under the Health Care Flexible Spending Plan through the end of the Coverage Period in which the Participant dies. The Participant's Spouse and Dependent(s) may be required to contribute to continue their participation.

4.8 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 to maintain the Participant's Health Care Flexible Spending Benefits 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 his or her Health Care Flexible Spending 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 premium with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer or with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any, including unused sick days and vacation days).

Coverage under a Participant's Health Care Flexible Spending Account will terminate if premium payments are not received by the due date established by the Employer. If a Participant's Health Care Flexible Spending Account or Dependent Care Assistance Account coverage ceases while on

USERRA leave for any reason (including for non-payment of premiums), the Participant will be entitled to re-enter the Health Care Flexible Spending Plan or the Dependent Care Flexible Spending Plan 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.

ARTICLE V
METHOD AND TIMING OF ELECTIONS

5.1 ELECTIONS WHEN FIRST ELIGIBLE

An Employee who first becomes eligible to participate in the Plan mid-year will commence participation after the Eligibility requirements have been satisfied on the earlier of the following:

- The 1st day of the pay period coincident with or following the Administrator's receipt and approval of an Election Agreement/Salary Reduction Agreement signed by the Employee; or
- The 1st day of the pay period coincident with or following 30 days from the date on which the Employee first becomes eligible.

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

5.2 ELECTIONS DURING OPEN ENROLLMENT PERIOD

During each Open Enrollment Period with respect to a Plan Year, the Administrator shall provide an Election Agreement/Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Election Agreement/Salary Reduction Agreement shall enable the Employee to elect to participate in the various components of the Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Agreement/Salary Reduction Agreement must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible 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 Election Agreement/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. Such use of an electronic system will have the same effect as a signed Election Agreement/Salary Reduction Agreement.

5.3 FAILURE OF ELIGIBLE EMPLOYEE TO FILE AN ELECTION AGREEMENT/SALARY REDUCTION AGREEMENT

If an Eligible Employee fails to file an Election Agreement/Salary Reduction Agreement or fails to complete his or her election using the electronic system (if any) provided by the Employer within the time described in Sections 5.1 and 5.2 as applicable, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash. Such Employee may not make a different election to participate in the Plan:

- (a) until the next Open Enrollment Period; or

(b) until an event occurs that would justify a mid-year election change.

5.4 IRREVOCABILITY OF ELECTIONS

Unless an exception applies (as described in Article VIII), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE VI
HEALTH CARE FLEXIBLE SPENDING PLAN

6.1 BENEFITS

An Eligible Employee can elect to participate in the Health Care Flexible Spending Plan by electing to receive benefits in the form of reimbursements for Medical Care Expenses (Health Care Flexible Spending Benefits). Benefits elected will be funded by Participant contributions as provided in Section 3.2.

Unless an exception applies (as described in Article VIII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 BENEFIT PREMIUMS

The annual premium for a Participant's Health Care Flexible Spending Account is equal to the annual benefit amount elected by the Participant.

6.3 ELIGIBLE MEDICAL CARE EXPENSES

Under the Health Care Flexible Spending Plan, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage and/or Grace Period for which an election is in force.

- (a) **Incurred.** A Medical 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.

Medical Care Expenses. Medical Care Expenses means expenses incurred by a Participant, Spouse or Dependent(s) for medical care, as defined in Code §213(d), including but not limited to care for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care, qualified long-term care services

- (b) other than expenses that are excluded by this Plan in (c) below, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other accident or health plan.
- (c) **Medical Expenses that are not reimbursable.** Insurance premiums and long-term care expenses are not reimbursable from the Health Care Flexible Spending Account.

6.4 MAXIMUM AND MINIMUM BENEFITS

- (a) **Maximum Reimbursement Available (Uniform Coverage).** The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses

incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage or Grace Period) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health Care Flexible Spending Account. The maximum dollar amount available for reimbursement of Medical Care Expenses incurred during the Grace Period shall be the maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during the Period of Coverage which ended on the last day of the Plan Year reduced by prior reimbursements made for expenses incurred during the Period of Coverage or Grace Period.

Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant is eligible for COBRA benefits. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VI have been satisfied.

- (b) **Maximum and Minimum Dollar Limits.** The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$5,000.00. There is no minimum annual benefit amount. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's Health Care Flexible Spending Account.
- (c) **Changes. No proration.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Agreement/Salary Reduction Agreement or another document. If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then there will be no proration rule (*i.e.* the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable).
- (d) **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual contributions to the Health Care Flexible Spending Account 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 premium for the period prior to such election change to;
 - The total premium for the remainder of such Period of Coverage to the Health Care Flexible Spending Account; reduced by
 - All reimbursements made during the entire Period of Coverage.

6.5 ESTABLISHMENT OF ACCOUNT

The Administrator will establish and maintain a Health Care Flexible Spending Account with respect to each Participant who has elected to participate in the Health Care Flexible Spending Plan, 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.

- (a) **Crediting of Accounts.** A Participant's Health Care Flexible Spending Account will be credited following each salary reduction actually made during each Period of Coverage with an amount equal to the salary reduction actually made.
- (b) **Debiting of Accounts.** A Participant's Health Care Flexible Spending Account will be debited during each Period of Coverage and during the Grace Period for any reimbursement of Medical Care Expenses incurred during the Period of Coverage and/or during the Grace Period.
- (c) **Available Amount Not Based on Credited Amount.** The amount available for reimbursement of Medical Care Expenses is the amount as calculated according to paragraph 6.4 (a) of this document. It is not based on the amount credited to the Health Care Flexible Spending Account at a particular point in time.

6.6 UNUSED YEAR END BALANCE

If a Participant has unused funds in his or her Health Care Flexible Spending Account at the end of the Plan Year, such Participant is allowed to carry over, from the unused funds, a maximum of \$5,000.00 for reimbursement of Medical Care Expenses incurred during the Grace Period. The Grace Period shall begin immediately following the end of the Plan Year and shall run through December 15th following the end of the Plan Year. If a balance remains in the Participant's Health Care Flexible Spending Account upon completion of the Grace Period such amount shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during the subsequent Plan Year beyond the Grace Period. The remaining amounts will be used by the Plan in the following ways:

- (a) First, to offset any losses experienced by State of Arizona during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the premiums paid by such Participant through Salary Reductions;
- (b) Second, to reduce the cost of administering the Health Care Flexible Spending Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); and
- (c) To provide increased benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Administrator deems appropriate, consistent with applicable regulations.

In addition, any Health Care Flexible Spending Account benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage or Grace Period in which the Medical Care Expense was incurred shall be applied as described above.

6.7 REIMBURSEMENT PROCEDURE

- (a) **Timing.** Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if approved by the Administrator), or the 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 Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.
- (b) **Claims Substantiation.** A Participant who has elected to receive Health Care Flexible Spending Benefits for a Period of Coverage may apply for reimbursement by submitting an application to the Administrator by no later than the date set by the Administrator each year. Such date shall not be earlier than January 31st following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:
- (1) The person or persons on whose behalf Medical Care Expenses have been incurred;
 - (2) The nature and date of the Expenses incurred;
 - (3) The amount of the requested reimbursement;
 - (4) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and
 - (5) Other such details about the Expenses that may be requested by the Administrator in the reimbursement request form or otherwise (for example, a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request.

- (c) **Claims Denied.** For appeals of claims that are denied, see Article IX.

6.8 REIMBURSEMENTS AFTER TERMINATION; LIMITED COBRA CONTINUATION

The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical 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 Section 6.7(b) following the close of the Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependent(s), whose coverage terminates under the Health Care Flexible Spending Plan because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that he or she had under the Health Care Flexible Spending Plan the day before the qualifying event (subject to all conditions and limitations under COBRA). The premiums 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 two percent (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 premium 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 will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health Care Flexible Spending Account will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Coverage may terminate sooner if the premium payments for a Period of Coverage are not received by the due date established by the Administrator for that Period of Coverage. Continuation coverage is only granted after the Administrator has received the premium payment for that period of coverage.

6.9 NAMED FIDUCIARY. COMPLIANCE WITH COBRA, HIPAA, ETC.

- (a) **Laws Applicable to Group Health Plans.** The Health Care Flexible Spending Plan shall be provided in compliance with COBRA, HIPAA, , and IRS.
- (b) **Coordination of Benefits.** Health Care Flexible Spending Plans are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health Care Flexible Spending Plan shall not be considered a group health plan for coordination of benefits purposes, and the Health Care Flexible Spending Plan shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING PLAN

7.1 BENEFITS

An Eligible Employee can elect to participate in the Dependent Care Flexible Spending Plan by electing to receive benefits in the form of reimbursements for Dependent Care Expenses (Dependent Care Flexible Spending Account Benefits). Benefits elected will be funded by the Participant on a pre-tax Salary Reduction basis, unless an exception applies (as described in Article VIII), such election is irrevocable for the duration of the period of coverage to which it relates.

7.2 BENEFIT PREMIUMS

The annual premium for a Participant's Dependent Care Flexible Spending Account Benefit is equal to the annual benefit amount elected by the Participant.

7.3 ELIGIBLE DEPENDENT CARE EXPENSES

Under the Dependent Care Flexible Spending Plan, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- (a) **Incurred.** A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense are furnished, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.
- (b) **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 Eligible 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 Dependent Care Flexible Spending Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.
- (c) **Qualifying Individual.** A Qualifying Individual is a Dependent who is under the age of 13 who lives with the Participant at least one half of the year or is the Participant's Spouse or older Dependent who is mentally or physically incapable of self-care who resides with the Participant for more than one half of the year and is a qualifying relative or child under Section 152 of the Code.
- (d) **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means the following: 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 Dependent Care Flexible Spending Plan and during the Period of Coverage; and are performed:

- (1) In the Participant's home; or
- (2) Outside the Participant's home for:
 - (i) The care of a Participant's Dependent who is under age 13, who resides with the Participant at least one half of the year; or
 - (ii) The care of any other Qualifying Individual who is mentally or physically incapable of self-care who resides with the Participant for more than one half of the year and is a qualifying child or relative under Section 152 of the Code.

In addition, if the expenses are incurred for services provided by a facility that provides care for more than 6 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.

(e) **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:

- (1) An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;
- (2) A Participant's Spouse;
- (3) A Participant's child who is under 19 years of age at the end of the year in which the expenses were incurred;
- (4) a Participant's Spouse's child who is under 19 years of age at the end of the year in which the expenses were incurred;
- (5) Overnight camps;
- (6) Instructional or sport specific camps (e.g. Ballet camp, soccer camp, summer school); or
- (7) Kindergarten or other educational expenses.

7.4 MAXIMUM AND MINIMUM BENEFITS

Maximum Reimbursement Available and Statutory Limits. The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's Dependent Care Flexible Spending Account less amounts debited to the Participant's Dependent Care Flexible Spending Account pursuant to Section 7.5.

Payment shall be made to the Participant in cash 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 Article VII have been satisfied.

Notwithstanding the foregoing, 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 applicable statutory limit. The applicable statutory limit for a Participant is the smallest of the following amounts:

- (a) The Participant's Earned Income for the calendar year;
- (b) The Earned Income of the Participant's Spouse for the calendar year (a Spouse who (1) is not employed during a month in which the Participant incurs a Dependent Care Expense; and (2) 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
- (c) \$5,000 for the calendar year, if:
 - (i) The Participant is married and files a joint federal income tax return; or
 - (ii) 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
 - (iii) The Participant is single or is the head of the household for federal income tax purposes.
- (d) \$2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

Maximum and Minimum Dollar Limits. The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be \$5,000.00 (subject to the other limitations described above). There is no minimum annual benefit amount.

Changes. No proration. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election

Agreement/Salary Reduction Agreement or another document. If a Participant enters the Dependent Care Flexible Spending Plan mid-year and wishes to increase his or her election mid-year when permitted under this Plan, then there will be no proration rule (*i.e.* the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable).

Effect on Maximum Benefits If Election Change Permitted. Any change in an election affecting annual contributions to the Dependent Care Flexible Spending Plan 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 premium for the period prior to such election change to
- the total premium for the remainder of such Period of Coverage to the Dependent Care Flexible Spending Plan, reduced by
- all reimbursements made during the entire Period of Coverage.

7.5 ESTABLISHMENT OF ACCOUNT

The Administrator will establish and maintain a Dependent Care Flexible Spending Account with respect to each Participant who has elected to participate in the Dependent Care Flexible Spending Plan, 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 under Section 7.6.

- (a) **Crediting of Accounts.** A Participant's Dependent Care Flexible Spending Account will be credited following each salary reduction actually made during each Period of Coverage with an amount equal to the salary reduction actually made.
- (b) **Debiting of Accounts.** A Participant's Dependent Care Flexible Spending Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.
- (c) **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 Dependent Care Flexible Spending Account, less any prior reimbursements.

7.6 UNUSED YEAR END BALANCE

If any balance remains in the Participant's Dependent Care Flexible Spending Account 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 a subsequent Plan Year. The remaining amounts will be used by the Plan in the following ways:

- (a) 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;
- (b) To reduce the cost of administering the Dependent Care Flexible Spending Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Administrator); and
- (c) To provide increased benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Administrator deems appropriate, and consistent with applicable regulations.

In addition, any Dependent Care Flexible Spending Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

7.7 REIMBURSEMENT PROCEDURE

- (a) **Timing.** Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses (if the Administrator approves the claim), or the 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 Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete and incomplete reimbursement claim.
- (b) **Claims Substantiation.** A Participant who has elected to receive Dependent Care Flexible Spending Plan Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Administrator by no later than the date set by the Administrator each year. Such date shall not be earlier than January 31st following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:
 - (1) The person or persons on whose behalf Dependent Care Expenses have been incurred;
 - (2) The nature and date of the Expenses incurred;
 - (3) The amount of the requested reimbursement;
 - (4) The name of the person, organization or entity to whom the Expense was or is to be paid;
 - (5) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and

- (6) Other such details about the expenses that may be requested by the 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 Administrator may request.

- (c) **Claims Denied.** For appeals of claims that are denied, see Section 9.

7.8 REIMBURSEMENTS AFTER TERMINATION

The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which participation terminates due to death of the Participant. However, the Participant's estate may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to the termination, including expenses incurred during the Plan Year following the termination, provided that the Participant's estate files a claim by the date established by the Administrator in Section 7.7(b).

7.9 REPORT TO PARTICIPANTS

On or before January 31 of each year, the Administrator shall furnish to each Participant who has received reimbursement for or made premium payments for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the Dependent Care Flexible Spending Account, as the Administrator deems appropriate.

ARTICLE VIII
IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

8.1 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 Article.

8.2 PROCEDURE FOR MAKING NEW ELECTION IF EXCEPTION TO IRREVOCABILITY APPLIES

- (a) **Timing for Making New Election if Exception to Irrevocability Applies.** A Participant may make a new election within 31 days of the occurrence of an event described in Section 8.4, as applicable, but only if the election under the new Election Agreement is made on account of and corresponds to the event.
- (b) **Effective Date of New Election.** Elections made pursuant to this Section shall be effective on the 1st day of the pay period following or coinciding with the 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. All election changes shall be effective on a prospective basis only (*i.e.*, election changes will become effective no earlier than the 1st day of the pay period following or coinciding with the date that the election change was filed, but, as determined by the Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).
- (c) **Changes. No Pro ration.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Agreement or other document. If a Participant enters the Dependent Care Flexible Spending Plan or the Health Care Flexible Spending Plan mid-year, or wishes to increase his or her election mid-year as permitted under Section 8.4, the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit for either plan, as applicable.
- (d) **Effect on Maximum Benefits.** Any change in an election affecting annual contributions to the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account 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 and Grace Period shall be calculated by adding:
 - (1) the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election; to

- (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account; reduced by
- (3) all reimbursements made during the entire Period of Coverage or Grace Period.

8.3 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 Administrator, in his or her sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

- (a) **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation or annulment;
- (b) **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 Dependent Care Flexible Spending Account, a change in the number of Qualifying Individuals as defined in Code § 21(b)(1) (for definition of Qualifying Individuals see Section 7.3);
- (c) **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:
 - (1) A termination or commencement of employment;
 - (2) A strike or lockout;
 - (3) A commencement of or return from an unpaid leave of absence;
 - (4) A change in worksite; or
 - (5) 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. For example, if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time, or vice versa, with the consequence that the employee ceases to be eligible for the Plan.

- (d) **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit. (For example, attaining a specified age, student status, or any similar circumstance.); and
- (e) **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

8.4 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 Plan:

- (a) **Open Enrollment Period.** A Participant may change an election during the Open Enrollment period.
- (b) **Termination of Employment.** A Participant's election will terminate upon termination of employment as described in the eligibility and participation Section.
- (c) **Leave of Absence.** A Participant may change an election upon a leave of absence as described in Article IV.
- (d) **Change in Status.** A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 8.3), 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 caused the Change in Status that affects the eligibility for coverage (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 (*i.e.*, a Spouse and/or Dependents) who may benefit from the coverage.

The 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:

- (1) **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 accident or health coverage for:
 - (i) The Spouse involved in the divorce, annulment, or legal separation;

- (ii) The deceased Spouse or Dependent; or
- (iii) 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.

- (2) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which 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 cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The 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 Administrator has reason to believe that the Participant's certification is incorrect.
- (e) **Certain Judgments, Decrees and Orders** (*Applies to the Health Care Flexible Spending Plan*). 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) requires accident or health coverage (including an election for Health Care Flexible Spending Plan Benefits) for a Participant's Dependent child, a Participant may:
- (1) Change an election to provide coverage for the Dependent child (provided that the order requires the Participant to provide coverage); or
 - (2) Change an election to revoke coverage for the Dependent child if the order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.
- (f) **Medicare and Medicaid** (*Applies to the Health Care Flexible Spending Plan*). If a Participant, Spouse or Dependent is enrolled in a health or accident plan or the aforementioned plans, 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 or accident coverage (including Health Care Flexible Spending Account coverage) of the person becoming entitled to Medicare or Medicaid. 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 accident or health coverage (including Health Care Flexible Spending Account coverage) for the individual who loses Medicare or Medicaid eligibility

(g) **Change in Cost** (*Applies to the Dependent Care Flexible Spending Account as limited below*). For purposes of this Section, "similar coverage" means coverage for the same category of benefits for the same individuals.

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

(i) Make a corresponding prospective increase to elective contributions (by increasing Salary Reductions); or

(ii) Drop coverage going forward if there is no other Benefit Option available that provides similar coverage.

The Administrator, on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(2) **Limitation on Change in Cost Provisions for Dependent Care Flexible Spending Account Benefits.** The above Change in Cost provision applies to Dependent Care Assistance Account Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee. For this purpose, a relative is an individual who is a child, parent, stepchild, sibling, aunt, uncle, cousin, or in-law of the Participant.

(h) **Change in Coverage** (*Applies to Dependent Care Flexible Spending Account Benefits*). The definition of "similar coverage" under Section 8.4(g) applies also to this Section.

(1) **Significant Curtailment.** If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under a benefit package 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 Administrator, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(2) **Significant Curtailment Without Loss of Coverage.** If the Administrator determines that a Participant's coverage under a Benefit Plan (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 Plan if offered, that provides similar coverage. 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.

- (3) **Significant Curtailment With a Loss of Coverage.** If the 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 Plan that provides similar coverage or drop coverage if no other Benefit Plan providing similar coverage is offered by the Employer.
 - (4) **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage (including the elimination of the Benefit Plan).
- (i) **Addition or Significant Improvement of a Benefit Plan** (*Applies to Dependent Care Flexible Spending Account Benefits*). If during a Period of Coverage, the Plan adds a new Benefit Plan or significantly improves an existing Benefit Plan, the Administrator may permit the following election changes:
- (1) Participants who are enrolled in a Benefit Plan other than the newly-added or significantly improved Benefit Plan that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Plan and instead to elect the newly added or significantly improved Benefit Plan; and
 - (2) Employees who are otherwise eligible under the eligibility and participation section may elect the newly added or significantly improved Benefit Plan on a prospective basis, subject to the terms and limitations of the Benefit Plan. The Administrator, on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.
- (j) **Change in Coverage Under Another Employer Plan** (*Applies to Dependent Care Flexible Spending Account Benefits*). 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
- (1) 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
 - (2) 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. For example, if an election is made by the Participant's Spouse during the Spouse's employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The 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, in accordance with prevailing IRS guidance.

(k) **Dependent Care Assistance Plan Coverage Changes** (*Dependent Care Flexible Spending Account Benefits*). A Participant may make a prospective election change that corresponds with a change in the dependent care service provider. For example:

- (1) 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
- (2) 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 Section 8.2.

8.5 ELECTION MODIFICATIONS REQUIRED BY ADMINISTRATOR

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

- (a) Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;
- (b) 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;
- (c) Maintain the qualified status of benefits received under this Plan; or
- (d) Satisfy Code 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 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.

ARTICLE IX
APPEALS OF DENIED CLAIMS

9.1 APPEALS OF DENIED CLAIMS UNDER THE PLAN

If a claim for reimbursement under the Health Care Flexible Spending Plan or Dependent Care Flexible Spending Plan is wholly or partially denied, or if a Participant is denied a benefit under State of Arizona Flexible Spending Accounts regarding his or her coverage under State of Arizona Flexible Spending Accounts (for example, a determination of: a Change in Status or eligibility and participation matters under State of Arizona Flexible Spending Accounts Plan document), then the claims procedure described below will apply.

If a claim is denied in whole or in part, the Administrator will notify the Participant in writing within 30 days of the date that the Administrator received the claim. (This time may be extended for an additional 15 days for matters beyond the control of the Administrator, including, in cases where a claim is incomplete. The Administrator will provide written notice of any extension, including the reason(s) for the extension and the date a decision by the Administrator 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:

- (a) The specific reason(s) for the denial;
- (b) The specific Plan provision(s) on which the denial is based;
- (c) 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
- (d) Appropriate information on the steps to take to appeal the Administrator's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review (upon request and at no charge) relevant documents and other information.

If a claim is denied in whole or part, a Participant (or his or her authorized representative) may request a review of the adverse benefits determination upon written application to the Committee (the Benefits Committee that acts on behalf of the Administrator with respect to appeals). A Participant (or his or her authorized representative) may request access to all relevant documents in order (1) to evaluate whether to request review of an adverse benefits determination and (2) 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. A written appeal should include: (1) additional documents, (2) written comments, and (3) 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 reference will be afforded to the initial determination.

A Committee, within a reasonable time, but no later than 60 days after the Committee receives the request for review, will decide the appeal. The Committee 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 a 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:

- (a) The specific reason(s) for the decision on review;
- (b) The specific Plan provision(s) on which the decision is based;
- (c) 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.

If a claim for reimbursement under the Health Care Flexible Spending Plan or Dependent Care Flexible Spending Plan is wholly or partially denied, or a Participant is denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue particular to the Participant's coverage under the Plan, then the claims procedures established by the Administrator and described above will apply.

ARTICLE X
RECORD KEEPING AND ADMINISTRATION

10.1 ADMINISTRATOR

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the 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 without discrimination.

10.2 POWERS OF THE ADMINISTRATOR

The Administrator shall have such duties and powers, as necessary or appropriate to discharge his or her duties. The Administrator shall have the exclusive right to interpret the Plan and to decide all matters there-under. All determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. The Administrator shall have the following discretionary authority:

- (a) 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 Committee shall exercise such exclusive power with respect to an appeal of a claim);
- (b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
- (c) To prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;
- (d) To request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) To furnish each Employee and Participant with such reports in relation to the administration of this Plan as the 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;
- (f) To receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;
- (g) 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;

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

10.3 RELIANCE ON PARTICIPANT, TABLES, ETC.

The Administrator may rely upon the direction, information or election of a Participant 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 a Participant. The 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 Administrator.

10.4 PROVISION FOR THIRD-PARTY PLAN SERVICE PROVIDERS

The Administrator may employ the services of such persons, as may be deemed necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Administrator.

10.5 COMPENSATION OF ADMINISTRATOR

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

10.6 INSURANCE CONTRACTS

The Employer shall have the right: (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. 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.

10.7 INABILITY TO LOCATE PAYEE

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such

person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

10.8 EFFECT OF MISTAKE

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

**ARTICLE XI
GENERAL PROVISIONS**

11.1 EXPENSES

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 6 and 7, and then by the Employer.

11.2 NO CONTRACT OF EMPLOYMENT

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period. All Employees are considered to be employed at the will of the Employer.

11.3 AMENDMENT AND TERMINATION

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Benefits Division or by any person or persons authorized by the Benefits Division to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

11.4 GOVERNING LAW

This Plan shall be construed, administered and enforced according to the laws of the State of Arizona, to the extent not superseded by the Code.

11.5 CODE COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code and of all of the regulations issued there under. 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.

11.6 NO GUARANTEE OF TAX CONSEQUENCES

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

To ensure compliance with requirements imposed by the IRS, that to the extent this communication (including any attachments) 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 (i) avoiding any penalties that may be

imposed on any Participant or any other person or entity under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein. All Participants should seek advice from an independent advisor based on their particular circumstances.

11.7 INDEMNIFICATION OF EMPLOYER

If any 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, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

11.8 SPENDTHRIFT CLAUSE

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 such extent as may be required by law.

11.9 HEADINGS

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or interpretation of any provision.

11.10 PLAN PROVISIONS CONTROLLING

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

11.11 SEVERABILITY

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

ARTICLE XII
HIPAA

12.1 COMPLIANCE WITH HIPAA

It is intended that this Plan meet all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and of all regulations issued there-under. 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 HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

(a) **Meaning of Payment.** Payment has the meaning specified in the Code of Federal Regulations §164.501. Specifically, Payment means:

- (1) The activities undertaken by:
 - (i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
 - (ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and
- (2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:
 - (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - (ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
 - (iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

- (v) Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
 - (vi) Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement: Name and address, Date of birth, Social Security Number, Payment history, Account number, and Name and address of the health care provider and/or health plan.
- (b) **Meaning of Health Care Operations.** Health care operations has the meaning as specified in the Code of Federal Regulations §164.501. Specifically, health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:
- (1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that obtaining general knowledge is not the primary purpose of any studies resulting from such activities; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
 - (2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in the areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
 - (3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;
 - (4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
 - (5) Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
 - (6) Business management and general administrative activities of the entity, including, but not limited to:

- (i) Management activities relating to implementation of and compliance with the requirements of this subchapter;
 - (ii) Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers, if PHI is not disclosed to such policyholder, plan sponsor, or customer;
 - (iii) Resolution of internal grievances;
 - (iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
 - (v) Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.
- (c) **As required by law and authorization.** The Plan will use and disclose PHI as required by applicable law and as permitted by authorization of the Participant and Eligible Dependents. With an authorization, the Plan will disclose PHI to the Employer's other medical, disability and workers' compensation plans for purposes related to administration of those plans.
- (d) **Disclosures to the Employer.** The Plan will disclose PHI to the Employer as sponsor of the Plan provided that the Employer agrees to:
- (1) Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
 - (2) Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
 - (3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;
 - (4) Not use or disclose PHI in conjunction with any other benefit or employee benefit plan of the Employer unless authorized by the individual;
 - (5) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
 - (6) Make PHI available to an individual in accordance with HIPAA's access requirements;

- (7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
 - (8) Make available the information required to provide an accounting of disclosures;
 - (9) Make 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 the purposes of determining the Plan's compliance with HIPAA; and
 - (10) 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 PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
- (e) **Employees with access to PHI.** In accordance with HIPAA, only the following employees of the Employer will be given access to PHI solely for the purpose of performing Employer Plan administration functions:
- (1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer; and
 - (2) Any employee with oversight responsibility for management of the Plan or any component of the Plan.

If the above employees do not comply with this Plan Document, the Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the State of Arizona Flexible Spending Accounts, State of Arizona has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 200 __.

State of Arizona

By: _____

Its _____

Witness

Signature: _____.

GLOSSARY

Administrator means State of Arizona.

Benefits means the Health Care Flexible Spending Plan Benefits and the Dependent Care Flexible Spending Plan Benefits offered under the Plan.

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

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: (a) any salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria Plan; (c) any compensation reduction under any Code §132(f) (4) Plan; and (d) any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

Dependent With regard to any health plan, a Dependent is a person who is a qualifying child or qualifying relative as defined in Code §152, without regard to the gross income limitations. With regard to the Dependent Care Flexible Spending Plan, a Dependent shall be a qualifying person as defined in Code §21(b)(1), as amended (See also "Qualifying Individual" under the Dependent Care Flexible Spending Plan.) In the case of divorced parents, the child shall be treated as a dependent of the custodial parent as described in Code §21(e)(5).

Dependent Care Expenses has the meaning described in the Dependent Care Flexible Spending Plan.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include: (a) any amounts received pursuant to any Dependent Care Flexible Spending Plan established under Code §129; or (b) 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 October 1, 2007.

Election Agreement/Salary Reduction Agreement means the form(s) or the Internet web site and procedures provided by the Administrator or obtained from the Internet web site. The Election Agreement will spell out the procedures used for allowing an Eligible Employee to participate in this Plan and will allow the Eligible Employee to elect Salary Reductions to pay for any benefits offered under this Plan.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in the Eligibility and Participation Section.

Employee means an individual that State of Arizona classifies as a common-law employee and who is on State of Arizona's W-2 payroll. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

Employer means State of Arizona

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 incurred during the Grace 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.

Highly Compensated Individual means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

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

Medical Care Expenses has the meaning defined in the Health Care Flexible Spending Plan.

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

Participant means a person who is an Eligible 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 Health Care Flexible Spending Benefits, or Dependent Care Flexible Spending Benefits, 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 any Health Care Flexible Spending or Dependent Care Flexible Spending Benefits.

Period of Coverage means the Plan Year, with the following exceptions: (a) 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 (b) 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.

Plan means the State of Arizona Flexible Spending Accounts as set forth herein and as amended from time to time.

Plan Year means the twelve-month period between October 1 and September 30 of the following calendar year.

Premium means the amount contributed to pay for the cost of Benefits as calculated under the Health Care Flexible Spending Plan and the Dependent Care Flexible Spending Plan.

PHI means protected health information.

Protected Health Information means information that is created or received by State of Arizona Flexible Spending Accounts 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 Dependent Care Flexible Spending Plan.

Qualifying Individual has the meaning described in the Dependent Care Flexible Spending Plan.

Related Employer means any employer affiliated with State of Arizona that, under Code §414(b), (c), or (m), is treated as a single employer with State of Arizona for purposes of Code §125(g)(4).

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 Benefits.

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

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

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

Appendix A

**Related Employers That Have Adopted This Plan,
With the Approval of State of Arizona.**

No Related Employers have adopted this Plan. State of Arizona is the only employer participating in this Plan.