PLAN DOCUMENT

FOR THE

STATE OF IOWA CAFETERIA PLAN

Originally Effective January 1, 2000

Amended and Restated October 1, 2015

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ARTICLE I. PURPOSE OF PLAN

The purpose of the State of Iowa Cafeteria Plan (the Plan) is to allow Eligible Employees to pay Benefit Costs and other medical, dental and dependent care expenses using pretax dollars.

The Plan consists of three plans: the premium conversion plan; the Dependent Care Flexible Spending Account Plan; and the Health Care Flexible Spending Account Plan. The Employer adopted the premium conversion plan on August 1, 1989, the Dependent Care Flexible Spending Account Plan effective April 1, 1990, and the Health Care Flexible Spending Account Plan effective January 1, 2000. The Employer has adopted the restated Plan effective January 1, 2000, and hereby adopts this amended and restated Plan as of October 1, 2015, notwithstanding the actual date of execution. The Plan is adopted for the exclusive benefit of those employees who are eligible to participate.

The Plan is intended to qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and shall be construed in a manner consistent with that Section. The Health Care Flexible Spending Account Plan is intended to qualify as a self-insured medical reimbursement plan under Code §105, and the Qualified Health Care Expenses are intended to be eligible for exclusion from Participants' gross income under Code §105(b). The Dependent Care Flexible Spending Account Plan is intended to qualify as a dependent care assistance program under Code §129, and the Qualified Dependent Care Expenses reimbursed are intended to be eligible for exclusion from Participants' gross income under Code §129(a).

The tax implications of this Plan are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the Employer does not represent or warrant to any Participant that any particular tax consequence will result from participation in this Plan. By participating in the Plan, each Participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Employer.

This Plan is intended not to discriminate as to eligibility or benefits in favor of any prohibited groups under Sections 105, 125, and 129 of the Code.

ARTICLE II. DEFINITIONS

The following words and phrases have the following meaning, unless a different meaning is plainly required by the text:

2.1 **Benefit Cost(s).** "Benefit Cost(s)" means the cost of medical, dental and life insurance under the Benefit Plan, which a Participant is required, as a condition for coverage, to defray. The amount of the Benefit Cost under the Benefit Plan shall be determined by the Employer in accordance with the Employer's written employment policies that are applied to all employees in a consistent manner.

2.2 **Benefit Plan.** "Benefit Plan" means the group plans offered by the employer for health insurance, dental insurance, and supplemental life insurance.

2.3 **Code.** "Code" means the Internal Revenue Code of 1986, as amended.

2.4 **Dependent.** Except as otherwise stated herein, "Dependent" means a dependent as defined in the applicable Benefit Plan. "Dependent" with respect to flexible spending accounts means a Spouse, a Qualifying Child, or a Qualifying Relative.

2.5 **Dependent Care Flexible Spending Account Plan.** "Dependent Care Flexible Spending Account Plan" means the plan offered by the Employer to allow Eligible Employees to set aside a portion of earnings to pay for Qualified Dependent Care Expenses.

2.6 **Dependent Care Reimbursement Account.** "Dependent Care Reimbursement Account" means the account the Employer establishes for each Dependent Care Flexible Spending Account Plan Participant. The Dependent Care Reimbursement Account so established is a record keeping account with the purpose of keeping track of contributions and determining forfeitures.

2.7 **Earned Income.** "Earned Income" means the sum of the amounts set forth under a. below, but shall exclude the amounts set forth under b. below:

a. Earned Income shall include the following:

1. wages, salaries, tips and other employee compensation; and

2. the amount of a Participant's net earnings from self-employment for the taxable year (within the meaning of Section 1402(a) of the Code). Such net earnings shall be determined with regard to the deductions allowed to the employee under Section 164(f) of the Code.

b. Earned Income shall exclude the following:

1. amounts received under this Plan or any other dependent care assistance plan under Section 129 of the Code;

2. amounts received as a pension or annuity (within the meaning of Section 32(c)(2) of the Code);

3. amounts to which Section 871(a) (relating to income of non-resident alien individuals not connected with United States business) of the Code applies;

4. amounts attributed to an individual pursuant to community property laws (within the meaning of Section 32(c)(2) of the Code); and

5. amounts attributable to wages or salary which were reduced pursuant to a written Salary Reduction Agreement.

2.8 **Eligible Employee**. "Eligible Employee" means all non-temporary employees who work at least 1,040 hours per calendar year.

2.9 **Employer.** "Employer" means the State of Iowa, including the eight judicial department of correctional services districts, and any other governmental employer that participates in the Plan.

2.10 **Health Care Flexible Spending Account Plan.** "Health Care Flexible Spending Account Plan" means the plan offered by the Employer to allow Eligible Employees to set aside a portion of earnings to pay for Qualified Health Care Expenses.

2.11 **Health Care Reimbursement Account.** "Health Care Reimbursement Account" means the account the Employer establishes for each Health Care Flexible Spending Account Plan Participant. The Health Care Reimbursement Account so established is a record keeping account with the purpose of keeping track of contributions and determining forfeitures.

2.12 **Incurred.** "Incurred" shall mean the date on which services are provided that gives rise to the expense regardless of when the expense is paid or billed.

2.13 **Participant.** "Participant" means an Eligible Employee who is participating in any portion of the Plan.

2.14 **Plan.** "Plan" means this State of Iowa Cafeteria Plan.

2.15 **Plan Year.** "Plan Year" means a twelve (12) consecutive month period beginning January 1 and ending December 31.

2.16 **Qualified Beneficiary.** "Qualified Beneficiary" means an individual who, on the day before a Qualifying Event defined in section 2.20 herein, is a Dependent of a Participant.

2.17 **Qualified Dependent Care Expenses.** "Qualified Dependent Care Expenses" means employment-related dependent care expenses eligible for reimbursement under the Plan as determined under Sections 129(e)(1) and 21(b) of the Code. Such expenses include amounts paid for household services and for the care of Qualifying Individuals enabling the Participant and the Participant's Spouse, if married, to be gainfully employed.

2.18 **Qualified Health Care Expenses.** "Qualified Health Care Expenses" means health care expenses as defined in Section 213(d) of the Code, which are not otherwise reimbursable under the Benefit Plan or other plan or entity, but not including any Benefit Cost or the premiums paid for any other health insurance coverage.

2.19 **Qualifying Child.** "Qualifying Child", for purposes of the flexible spending account plans, means:

a. a child (by birth or adoption), stepchild, or eligible foster child who turns age 26 or younger during the current Plan Year; and

b. a grandchild, sibling, stepsibling, or a descendant of any such relative who:

1. shares the Participant's principal residence for more than one-half of the year;

2. for whom the Participant provides over one-half of the financial support;

3. who is under age 19 if not a Student, and under age 24 if a Student; and

4. who has not filed a joint return (other than only for a claim of refund) with the individual's spouse under Section 6013 for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins.

2.20 **Qualifying Event.** "Qualifying Event" means any of the following:

a. termination of coverage due to the death of a Participant or the Participant's Spouse;

b. termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or loss of eligibility due to a reduction in hours of a Participant;

c. the divorce or legal separation of a Participant; or

d. a Dependent ceasing to be a Dependent.

2.21 **Qualifying Individual.** "Qualifying Individual" for purposes of the Dependent Care Flexible Spending Account Plan, means:

a. a Dependent of a Participant who is under the age of thirteen (13) and with respect to whom the Participant is entitled to a deduction under Code §151(c) of the Code; or

b. a Dependent of a Participant who is physically or mentally incapable of self-care (within the meaning of Code §Section 21 of the Code).

2.22 **Qualifying Relative.** "Qualifying Relative" for purposes of the flexible spending account plans means a person who:

a. bears one of the following relationships to the Participant:

1. a child or descendant of a child;

2. a brother, sister, stepbrother, or stepsister;

3. a father or mother, or an ancestor of either;

4. a stepfather or stepmother;

5. a son or daughter of a brother or sister of the Participant;

6. a brother or sister of the father or mother of the Participant;

7. a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or

8. an individual (other than an individual who at any time during the taxable year was the spouse, determined without regard to Section 7703, of the taxpayer) who, for the taxable year of the taxpayer, has the same principal place of abode as the taxpayer and is a member of the taxpayer's household; and

b. has gross income for the calendar year in which such taxable year begins that is less than the exemption amount (as defined in Code §151(d));

c. for whom the Participant provides over one-half of the financial support; and

d. is not a Qualifying Child of the Participant or of any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins.

2.23 **Salary Reduction Agreement.** "Salary Reduction Agreement" means a written agreement, or an electronic request submitted online, by a Participant to reduce salary or wages to fund a Benefit Plan or a flexible spending account.

2.24 **Spouse.** "Spouse" means the spouse of a Participant but shall not include an individual legally separated from a Participant under a decree of divorce or of separate maintenance.

2.25 **Student.** "Student" means an individual who, during each of five (5) calendar months during a taxable year, is a full-time student at an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility.** All Eligible Employees are eligible to participate in the Plan. An Employee must be eligible to participate in the Benefit Plan on the first day of the Plan

Year to be a Participant in the Plan on that day. Employees who become eligible during the Plan Year shall be allowed to participate in the Plan for the remainder of the Plan Year following their eligibility date.

3.2 **Participation.** Participation is established on a Plan Year to Plan Year basis. Each Eligible Employee shall be a Participant in the Plan for a Plan Year as follows:

a. **Premium Conversion.** For purposes of receiving Benefit Cost benefits under section 4.1, participation will be automatic, unless a Participant elects not to participate under this Plan for a Plan Year for purposes of Benefit Costs. A Participant who is eligible to participate may elect not to participate by completing and filing an appropriate declination form with the Employer within the election period established by the Employer. An employee who elects not to participate with regard to payment of Benefit Costs shall pay for such Benefit Costs under the Benefit Plan on an after-tax basis.

b. **Flexible Spending Accounts.** For purposes of receiving reimbursement from the Health Care Flexible Spending Account Plan and/or the Dependent Care Flexible Spending Account Plan, participation begins when the appropriate valid Salary Reduction Agreement(s) have been filed or entered electronically in an online system, and become effective under Article VI. A Participant's Salary Reduction Agreement shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year.

c. **Health insurance opt-out.** An opt-out eligible employee, as defined below, may voluntarily receive a cash payment in lieu of health insurance. The amount of the payment will be set by the employer. Employees may opt out of health insurance upon first becoming eligible for the opt-out, as a result of a qualifying life event, or during the annual enrollment and change period. The payment is taxable income for the purposes of federal, state, and Social Security/Medicare taxes.

To be eligible for the opt-out payment, an employee must:

1. Be an executive branch non-contract employee or an employee covered by the State Police Officers Council;

2. Be a full-time (be scheduled to work 30 or more hours per week) benefit-eligible employee; and

3. Not be covered by any state-sponsored (active, retiree, or Board of Regents) health insurance plan through a family member, including a domestic partner.

3.3 **Changes to Participation.** A Participant may not revoke or amend participation in the Plan during a Plan Year except under the events listed below. An election change is allowed only when eligibility for coverage under a Benefit Plan or a flexible

spending account is affected by one of the events listed below. A request for revocation or amendment of participation must be submitted within thirty (30) days after the event has occurred and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the revocation or amendment is submitted.

a. **Change in Status.** On account of a change in status and the revocation or amendment corresponds to, is consistent with, and on account of the change in status as defined in Section 125 of the Code. Changes in status are defined as changes in:

1. **Legal marital status.** Events that change a Participant's legal marital status, including the following: marriage, death of Spouse, divorce, legal separation, and annulment.

2. **Number of Dependents.** Events that change a Participant's number of Dependents, including the following: birth; death, adoption, and placement for adoption. In the case of the Dependent Care Flexible Spending Account Plan, the change must be in the number of Qualifying Individuals.

3. **Employment status.** Any of the following events that change the employment status of the Participant or the Participant's Dependent:

- a termination or commencement of employment;
- a strike or lockout;
- a commencement of or return from an unpaid leave of absence of more than 30 days; or
- a change in work-site.

In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the employer of the Participant, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment (e.g., if a plan only applies to salaried employees and a Participant's Spouse switches from salaried to hourly-paid with the consequence that the Participant's Spouse ceases to be eligible for the plan, then that change constitutes a change in employment status).

4. **Dependent satisfies or ceases to satisfy eligibility requirements.** Events that cause a Participant's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

5. **Change in residence.** A change in the place of residence of the Participant or Dependent as long as the change in residence causes a change in eligibility under a Benefit Plan.

b. **Judgment, Decree, or Order.** If a judgment, decree, or order is issued due to a divorce, legal separation, annulment, or change in legal custody that requires Benefit Plan coverage of a Participant's child or foster child who is a Dependent of the Participant, the Participant may make a change in a Benefit Plan or a health flexible spending account.

c. **Medicare or Medicaid Entitlement.** If a Participant or Dependent who is enrolled in a Benefit Plan becomes eligible for Medicare or Medicaid, or loses eligibility for Medicare or Medicaid, the Participant may make a change to the Participant's health insurance plan or health flexible spending account consistent with the gain or loss of eligibility.

d. **Significant Cost or Coverage Change.** If the cost or coverage of a Benefit Plan or the cost or coverage of a Participant's dependent care provider significantly increases or decreases during the Plan Year, the Participant may make a corresponding change to his or her selection of a Benefit Plan or their dependent care annual election. An insignificant cost change will result in an automatic adjustment to the Participant's Salary Reduction Agreement.

e. **Family and Medical Leave.** A Participant taking leave under the Family and Medical Leave Act may revoke an existing election and make another election for the remainder of the Plan Year.

f. **Special Enrollment Rights.** A Participant may revoke an election for coverage in a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code sec. 9801(f). In such cases, the Salary Reduction Agreement shall automatically change.

g. **Enrollment in a Group Health Plan that Offers Minimal Essential Coverage or in a Health Care Exchange or Marketplace.** An Employee may make a **prospective** election change that is on account of and corresponds with a change to the Employee's health insurance election, so long as:

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

- The Employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or the Employee seeks to enroll

in a Marketplace during the Marketplace's annual open enrollment period; AND the Employee enrolls in the Marketplace with a new coverage effective date no later than the day immediately following the last day the original coverage is revoked.

h. **Other**. Other circumstances that the administrator determines will qualify under Section 125 of the Code.

3.4 **Termination of Participation.** Except as provided in Section 3.5 below, participation with regard to Benefit Cost(s) and Qualified Health Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following: the last day of the month in which a Participant's last salary reduction was made, the effective date the applicable Salary Reduction Agreement is revoked, or the date the Plan is terminated. Participation with regard to a Benefit Plan terminates on the first to occur of the following: the last day of the month in which a Participant terminates employment, the effective date the applicable Salary Reduction Agreement is revoked, or the date the Plan is terminated.

Notwithstanding any provision of the Plan to the contrary, coverage with regard to Qualified Dependent Care Expenses provided under this Plan during a Plan Year terminates on the earlier of the end of the Plan Year or the date the Plan is terminated.

The former Participant shall be entitled to submit a request for reimbursement of Qualified Health Care Expenses and Qualified Dependent Care Expenses, in accordance with Article VII, provided such Qualified Health Care Expenses were incurred while the former Participant participated in the Plan and Qualified Dependent Care Expenses were incurred prior to the end of the Plan Year. A Participant will not be eligible for reimbursement of Qualified Health Care Expenses or Qualified Dependent Care Expenses incurred prior to the effective date of his/her participation under the Health Care Flexible Spending Account Plan or the Dependent Care Flexible Spending Account Plan.

If participation terminates due to a separation of service and the individual returns to eligible employment within 30 days in the same Plan Year, then the Participant's election will be reinstated as it was immediately prior to the separation of service. If participation terminates due to a separation of service and the individual returns to eligible employment after 30 days in the same Plan Year, then the Participant may make a new election for the remainder of the Plan Year. If salary reduction contributions were not made during the separation of service, the Participant will not be able to be reimbursed for expenses incurred during the separation.

Notwithstanding any provisions of the Plan to the contrary, a former Participant may under circumstances specified in 3. 5, elect to continue coverage for Qualified Health Care Expenses by submitting the required self-payment premiums as set forth in section 3.5 herein.

3.5 Continuation Coverage for the Health Care Flexible Spending Account Plan.

a. **Eligibility.** If on the date of the Qualifying Event, a former Participant or a Qualified Beneficiary has remaining Qualified Health Care Expense in excess of remaining contributions in the Participant's Health Care Flexible Spending Account Plan, then the Participant may continue coverage for Qualified Health Care Expenses for the remainder of the Plan Year, by making an election to do so with the Employer and submitting the applicable self-payment contribution. The Employer will establish the amount of the monthly self-payment contribution.

b. **Procedures to Elect Self-Payment for Continuation Coverage.**

1. **Death or Termination of Employment.** In the case of a Qualifying Event described in Section 2.18, a. or b., (death or termination of employment or reduction in hours) a Qualified Beneficiary will receive information concerning continuation coverage, including the self-payment rates, within fourteen (14) days of loss of coverage.

2. **Divorce or Child No Longer a Dependent.** In the case of a Qualifying Event as described in Section 2.18, c. or d., (legal separation or divorce, or a Dependent no longer qualifies as a Dependent) a Qualified Beneficiary must notify the Employer within sixty (60) days of the Qualifying Event. If notice is not received within sixty (60) days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage. Following receipt of timely notice of a Qualifying Event and within fourteen (14) days of receipt of such notice, the Employer will provide the Qualified Beneficiary with information concerning continuation coverage and rates.

3. **Election of Coverage.** After notification of continuation coverage, the former Participant or Qualified Beneficiary will have sixty (60) days to elect continuation coverage, after the **later** of:

(a) the date that the former Participant or Qualified Beneficiary would lose coverage on account of the Qualifying Event; or

(b) the date that the former Participant or Qualified Beneficiary is sent such notice.

The election must specify which Qualified Beneficiaries are electing COBRA continuation coverage. If it does not specify the Qualified Beneficiaries, the election shall be deemed to be an election on behalf of all Qualified Beneficiaries.

4. **Payment.** The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Employer within forty-five (45) days of the date the former Participant or Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first (1st) day of the month for which coverage

is elected, and shall be considered timely if received within thirty (30) days of the date due.

5. **Nonpayment of Premiums.** If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Employer in accordance with paragraph 4.

c. **Termination of Continuation Coverage.** Continuation coverage as provided under this section will terminate on the **earliest** of the following dates, as applicable:

1. the date after the election of continuation coverage that the former Participant or Qualified Beneficiary first becomes covered under any other group medical coverage as a participant or dependent. In the event such other group medical coverage has a pre-existing condition clause or limitation, continuation coverage will not terminate until exhaustion of the maximum period continuation coverage is allowed or until the pre-existing condition clause or limitation has been satisfied;

2. the end of the period for which the last payment was made for coverage in a timely manner;

3. the end of the Plan Year; or

4. the date the Employer ceases to provide the Health Care Flexible Spending Account Plan.

3.6 **Death of a Participant.** With respect to Qualified Dependent Care Expenses, if a Participant dies, the Participant's participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of the Participant's estate, may submit claims for expenses or benefits for the remainder of the Plan Year or until the account balance is exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Employer may designate the Participant's Spouse, one (1) of the Participant's dependents, or a representative of the Participant's estate.

3.7 **Paid FMLA Leaves of Absence.** To the extent required by the Family and Medical Leave Act (FMA), the Participant will continue to have coverage under the applicable Benefit Plans and the Health Care Flexible Spending Account Plan while on a qualifying paid FMLA leave. Coverage will terminate for a Participant in the Dependent Care Flexible Spending Account Plan unless the Participant is incapable of self-care.

3.8 **Unpaid FMLA Leaves of Absence.** If a Participant is on a qualifying unpaid FMLA leave, the Employer shall continue to pay its share of Benefit Costs. If the Participant is required to pay a share of the Benefit Costs, the Participant may prepay the amount owing for the anticipated leave, or may pay the Participant's share of Benefit Costs on a monthly basis. Participants may pay contributions to the Health Care Reimbursement Account by prepaying the amount owed, making monthly payments,

or making payments upon return to employment. If the Participant fails to make required payments, coverage for the applicable Benefit Plan or flexible spending account plan shall cease after a 30 day grace period. The Participant may submit claims for eligible expenses incurred before participation ended. If coverage was terminated while on FMLA leave, upon return to employment the Participant may choose to re-instate the election as it was immediately prior to the leave. However, such Participant shall have no greater rights to coverage or election changes than had the Participant not been on such leave.

3.9 **Military Leave**. If a Participant goes on a qualifying leave under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), to the extent required by USERRA, the Participant may continue coverage in the applicable Benefits Plans and flexible spending account plans. In the event of an unpaid USERRA leave, a Participant may elect to continue participation during the leave as follows:

a. Health and dental insurance coverage may be continued for dependents through COBRA for up to 24 months. The Participant may send monthly payments to the Employer by the due date established by the Employer. Coverage will terminate if payments are not received timely.

b. Participation in basic and supplemental life insurance and long term disability ends when the Participant reports for active duty.

c. A Participant may elect to continue participation in the Health Care Flexible Spending Account Plan for the remainder of the Plan Year. Participants may prepay the remaining contributions before going on unpaid leave, or may pay the regular monthly amounts with post-tax dollars to the Employer. Participants who elect to continue coverage may receive reimbursement for claims incurred for the remainder of the year. Participants who do not elect to continue coverage may receive reimbursement for claims incurred through the end of the month in which they last contributed to their flexible spending account.

d. A Participant may elect to continue participation in the Dependent Care Flexible Spending Account Plan. Participants may prepay contributions before going on unpaid leave, but do not need to make post-tax contributions. Any available funds in the account may be used for eligible expenses incurred through the remainder of the year, regardless of whether a contribution is made during that month.

ARTICLE IV. BENEFITS

4.1 **Benefit Cost.** The Benefit Cost of a Participant for the Benefit Plan shall be paid by the Employer subject to the provisions of Section 5.1.

4.2 **Qualified Health Care Expenses.** The Employer shall reimburse a Participant for Qualified Health Care Expenses incurred by the Participant or the Participant's Dependent.

Reimbursement for Qualified Health Care Expenses during a Plan Year is limited to the annualized amount directed by the Participant to the Health Care Reimbursement Account under a valid Salary Reduction Agreement. The full annual election for the Health Care Reimbursement Account shall be available to the Participant from the first day of the Plan Year.

4.3 **Qualified Dependent Care Expenses.** The Employer shall reimburse a Participant for Qualified Dependent Care Expenses in accordance with the provisions of section 5.3.

Reimbursement for Qualified Dependent Care Expenses during a Plan Year is limited to the amount of expenses incurred, not to exceed the amount in the Participant's account at the time a claim is made.

4.4 **Determination of Noncompliance.** In the event that a determination is made that all or any part of the contributions to the Plan do not qualify as non-taxable contributions to a "Cafeteria Plan" or a "Dependent Care Assistance Program" under Sections 125 and 129 of the Code, the affected contributions made by any Participant shall be treated as salary and, to the extent not yet expended, returned to such Participant. The Participant shall pay:

a. any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed thereon;

b. the Participant's share (as determined in good faith by the Employer) of any applicable FICA or FUTA contributions which would have been withheld from such amounts by the Employer had such amounts been treated as salary and not as Qualifying Dependent Care Expenses or Qualified Health Care Expenses; and

c. an amount (as determined in good faith by the Employer) equal to the portion of any applicable penalties and interest payable by the Employer as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the Participant.

ARTICLE V. FUNDING

5.1 **Funding of Benefit Cost.** In return for the Employer payment of a Participant's Benefit Cost under Section 4.1, the Participant agrees to reduce the Participant's salary or wage each month by the amount of the Benefit Cost under the Benefit Plan through a valid Salary Reduction Agreement. The premium amounts paid through salary reduction will be adjusted during a Plan Year to reflect changes in the Benefit Cost.

5.2 Funding of Qualified Health Care Expense Account.

a. Qualified Health Care Expenses shall be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year.

b. A Participant's salary or wage may be reduced under this section 5.2 in an amount not to exceed the greater of $3,000 or the statutory maximum as determined by federal law. The salary reduction amount so elected shall be funded pro rata over the twenty-four (24) consecutive pay periods in the Plan Year. The salary reduction amount for any one (1) pay period may not exceed the amount of the Participant's salary or wage for that period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

c. The Employer shall establish individual Health Care Reimbursement Accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.2.

d. The Employer shall reimburse Participants for Qualified Health Care Expenses in accordance with Article VII.

5.3 Funding of Dependent Care Reimbursement Account.

a. Qualified Dependent Care Expenses may be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year, not to exceed the amount in the Participant's account at the time reimbursement is required.

b. A Participant's salary or wage may be reduced under this Section 5. 3 in an amount not to exceed $5,000 ($2,500 if the Participant is married and files a separate federal tax return) or the Participant's Earned Income, whichever is lower, for each Plan Year. The salary reduction amount so elected shall be funded pro rata over the twenty-four (24) consecutive pay periods in the Plan Year. The salary reduction amount for any one pay period may not exceed the amount of the Participant's salary or wage for the pay period. Salary reduction amounts for a pay period shall be reduced by the amount they exceed the Participant's salary or wage for that period.

c. The Employer or its designated agent shall establish individual Dependent Care Reimbursement Accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.3.

5.4 Accounting. The Employer or its designated agent shall maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Qualified

Health Care Expenses or Qualified Dependent Care Expenses on behalf of any Participant.

ARTICLE VI. SALARY REDUCTION ELECTIONS

6.1 Election Period for Salary Reduction.

a. In order to fund a Health Care Reimbursement Account or Dependent Care Reimbursement Account for a Plan Year, a Participant must complete and file with the Employer an appropriate Salary Reduction Agreement election form within the applicable election period, or must submit such election electronically in an online system provided by the Employer.

b. The periods for submitting Salary Reduction Agreement elections shall be as established by the Employer.

6.2 Termination, Revocation, or Amendment of Salary Reduction Elections.

a. A Participant's Salary Reduction Agreement election for a Plan Year with respect to Qualified Health Care Expenses and Qualified Dependent Care Expenses shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year. A Participant's Salary Reduction Agreement election for a Plan Year with respect to Benefit Costs shall not terminate at the end of the Plan Year.

b. Termination, revocation or amendment of salary reduction elections may only be made by a Participant in accordance with Article III.

6.3 Limitations on Exclusion From Gross Income for Dependent Care Reimbursement Account.

a. Unless otherwise provided by the Code, reimbursements under the Plan for Qualified Dependent Care Expenses shall be excluded from the gross income of a Participant during a Plan Year in accordance with Code Section 129. Exclusion from gross income under the Plan shall not exceed:

1. in the case of a Participant who is not married at the close of such Plan Year, the Earned Income of such Participant for such Plan Year; or

2. in the case of a Participant who is married at the close of such Plan Year, the lesser of the Earned Income of such Participant or the Earned Income of the Spouse of such Participant for such Plan Year.

The aggregate amount excluded from the gross income of a Participant under this Plan for a Plan Year shall not exceed $5,000 ($2,500 in the case of a separate return by a married individual).

To the extent reimbursements exceed the maximum amount excludable from a Participant's gross income, the reimbursements shall be treated as taxable income to the Participant.

b. The amount excluded from the income of a Participant under the Plan for any Plan Year shall not include:

1. payments made or incurred to an individual who can be claimed as a Dependent of the Participant; or

2. payments made or incurred to an individual who is a child, under the age of nineteen (19) at the end of the Plan Year, of such Participant or the Spouse of such Participant.

6.4 Forfeiture of Salary Reduction Amounts.

a. All monies held by the Employer attributable to salary reduction amounts to pay for a Participant's Benefit Cost for coverages under the Benefit Plan which are in excess of such Benefit Costs for a Plan Year shall be forfeited by the Participant to the Employer at the end of the relevant Plan Year, except for the exclusion listed in c below.

b. If a Participant fails to claim any amounts in the Health Care Flexible Spending Account Plan or the Dependent Care Flexible Spending Account Plan by the time allowed in Section 7.4(d) and Section 7.5(d), such amounts shall be forfeited by the Participant to the Employer, except for the exclusion listed in c below.

c. Notwithstanding any other provision of the Plan to the contrary, if any balance remains in the Participant's Health Care Reimbursement Account (and any other health FSA maintained by the Employer) after all reimbursements have been made for the Period of Coverage, a maximum of $500 shall be carried over to reimburse the Participant for Qualified Health Care Expenses incurred during a subsequent Plan Year. If any balance in excess of $500 remains in the Participant's Health Care Reimbursement Account after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Qualified Health Care Expenses incurred during a subsequent Plan Year. All remaining amounts in excess of $500 per account will be used by the Plan as stated in the Plan Document.

d. All forfeitures under this Plan shall be used as follows:

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

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

ARTICLE VII. PAYMENT OF CLAIMS

7.1 **Determination of Status of Eligible Expenses**. After receiving an appropriately submitted claim and the information required under Sections 7.4 or 7.5, the Employer or designated agent shall determine whether such expenses are Qualified Health Care Expenses or Qualified Dependent Care Expenses. The Employer may delegate the authority to administer claims under the Plan to a designated agent.

7.2 **Payment of Claims**. The Employer or designated agent will pay properly submitted claims for reimbursement at such intervals as it may consider appropriate.

7.3 **Expenses**. All administrative expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan shall be paid by the Employer

7.4 **Claims Reimbursement for Qualified Health Care Expenses**.

a. The Participant must submit a properly completed claim form to the Employer or the designated agent along with written evidence from an independent third party stating the Qualified Health Care Expense has been incurred, the amount of such expense, and such other information as the Employer may find necessary.

b. The Participant must submit with other required documents a signed statement in such form as determined by the Employer certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Health Care Expenses and are not reimbursable from any other source.

c. The Employer reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Health Care Expenses.

d. All claims for reimbursement must be faxed or postmarked no later than April 15th following the end of the Plan Year for which the expense was incurred, or other later date as may be established from time to time by the Employer. If April 15th falls on a weekend or holiday, claims must be submitted no later the next business day following April 15th.

7.5 Claims Reimbursement for Qualified Dependent Care Expenses.

a. To make a claim for reimbursement of Qualified Dependent Care Expenses, the Participant shall submit a statement to the Employer or the designated agent on an appropriate form adopted by the Employer containing the following information:

1. the Qualifying Individual(s) for whom the Qualified Dependent Care Expenses were incurred;

2. information necessary to substantiate that the dependent or dependents are Qualifying Individuals, such as the age of the dependent or a statement as to the physical or mental capacity of the dependent;

3. the nature of the services which will generate the Qualified Dependent Care Expenses;

4. written evidence from an independent third party stating the expenses have been incurred, the amount of such expense, and such other information as the Employer or the designated agent in its sole discretion may request; and

5. a statement that the Qualified Dependent Care Expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.

b. The Participant must submit with other required documents a signed statement in such form as determined by the Employer certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Dependent Care Expenses. For all who are Participants as of December 31 of the Plan Year, services must be incurred by December 31 of the Plan Year to be eligible for reimbursement from that Plan Year's funds. Effective with the 2008 Plan Year, services for those who are Participants as of December 31 of the Plan Year must be incurred by March 15 following the Plan Year to be eligible for reimbursement from that Plan Year's funds.

c. The Employer reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Dependent Care Expenses.

d. All claims for reimbursement must be faxed or postmarked not later than April 15th following the end of the Plan Year in which the expense was incurred, or other later date as may be established from time to time by the Administrator.

If April 15th falls on a weekend or holiday, claims must be submitted no later the next business day following April 15th.

ARTICLE VIII. ADMINISTRATION

8.1 **Employer Powers and Duties.** The Employer shall manage and administer the Plan. The Employer shall interpret the Plan and decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Employer with respect to any matter under the Plan shall be conclusive and binding on all persons. The Employer shall:

a. Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.

b. Make and enforce administrative rules and prescribe the use of such forms as it considers necessary for the efficient administration of the Plan.

c. Decide questions concerning the Plan and the eligibility of any employee to participate in the Plan, in accordance with the provisions of the Plan.

d. Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan, and provide a review to any Participant whose claim for benefits has been denied in whole or in part.

8.2 **Additional Operating Rules.** The Employer makes no guarantee as to the taxability of a Participant's salary reduction amount.

Salary reduction amounts under this Plan shall not reduce salary or wage amounts for purposes of any other Employer-sponsored employee benefit programs unless the provisions of those programs otherwise provide.

ARTICLE IX. APPEALS PROCEDURE

9.1 **Notice to Employee.** Any person who claims he/she has been denied a benefit under the Plan shall be entitled, upon written request to the Employer to receive, within 30 days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefor, citing pertinent provisions of the Plan and a statement of the procedure to be followed in requesting a review of his or her claim.

9.2 **Appeal of Denial of Benefit.** If the claimant wishes further consideration of his/her claim, he/she may request a review. The Employer shall schedule a review on the issue within thirty (30) days following receipt of the claimant's request for such

review. The decision following such review shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Employer as to all claims shall be final.

ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN

The Employer reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modifications or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Employer reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine.

ARTICLE XI. GENERAL PROVISIONS

11.1 **No Right to be Retained in Employment.** Nothing contained in the Plan shall give any Employee the right to be retained in the employment of any Employer or affect the right of the Employer to dismiss any Employee.

11.2 **Alienation of Benefits.** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so is void.

11.3 **Use of Form Required.** All communications in connection with the Plan made by a Participant are effective only when duly executed on forms provided by and filed with the Employer or its designated agent, or by data submitted electronically in an online system provided by the Employer.

11.4 **Applicable Law.** The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of Iowa.

11.5 **Statement of Benefits.** On or before January 31 of each year, the Employer or its designated agent will furnish each Participant who received benefits under the Plan a written statement on appropriate forms required by the federal Internal Revenue Service, showing the amounts paid or incurred by the Plan in providing reimbursement under the Plan for Qualified Dependent Care Expenses with respect to the Participant for the prior Plan Year.

11.6 **Gender and Number.** The masculine pronoun whenever used shall include the feminine, the neuter pronoun shall include both the masculine and the feminine and the singular may include the plural, and vice versa, as the context may require.

11.7 **State Assets.** Except for the unsecured contractual right to receive benefits payable under the Plan, no person shall have any right, title or interest in, or to the assets of, the State.

11.8 **Severability.** If any provision of this Plan is held to be illegal or invalid for any reason, that illegality or invalidity will not affect the remaining parts of this Plan. In such case, this Plan will be enforced as if the illegal or invalid provision were not included in the Plan.

Department of Administrative Services

By: _____ Date 10/13/2015

Janet E. Phipps, Director