STATE OF NEW MEXICO

GENERAL SERVICES DEPARTMENT
RISK MANAGEMENT DIVISION

FLEXIBLE BENEFITS PLAN

Originally Effective January 1, 2005
Amended and Restated October 1, 2021

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ARTICLE I: INTRODUCTION

1.1 ESTABLISHMENT OF PLAN

State of New Mexico (the "Employer") hereby establishes the State of New Mexico Flexible Spending Accounts (the "Plan") originally effective January 1, 2005 and amended June 30, 2011. The Plan is hereby amended and restated effective October 1, 2021 (the "Effective Date"), notwithstanding the actual date of execution.

1.2 PURPOSE OF THE PLAN

This Plan is designed to permit an Eligible Employee to pay his or her share of the premiums of the various insurance plans sponsored by the Employer on a pre-tax Salary Reduction basis, and to contribute on a pre-tax Salary Reduction basis to an account 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 Internal Revenue Code (the "Code") §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health Care Reimbursement 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 Assistance 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 Reimbursement Plan and the Dependent Care Assistance Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129. The Health Care Reimbursement Plan is also a separate plan for purposes of applicable provisions of COBRA.

1.4 AMERICAN RESCUE PLAN ACT OF 2021 – TEMPORARY PROVISIONS

Notwithstanding any provision to the contrary contained in this Plan, in accordance with the authority granted by the Internal Revenue Serivce pursuant to the American Rescue Plan Act of 2021 and other Federal laws, this Plan is amended to:

(1) allow Eligible Employees to apply any unused amounts remaining in their Health Care Reimbursement Plan and the Dependent Care Assistance Plan as of the end of plan years ending in 2020 or 2021 to reimburse expenses incurred for the same qualified benefit (medical care or dependent care) through December 31, 2021 and December 31, 2022, respectively;

(2) allow an Eligible Employee who ceases participation in the Plan during calendar year 2020 or 2021 as the result of termination of employment, change in employment status, or a new election during calendar year 2020 or 2021, to continue to receive reimbursements from unused benefits or contributions through the end of the plan year in which participation ceased (including the Grace Period); provided that the extension period is limited to the end of the plan year in which participation ceased (including the Grace Period; and

(3) for plan year ending in 2021, subject to timing limitations established by the Employer and without regard to any change in status, allow an Eligible Employee who is not currently enrolled in a Health Care Reimbursement Plan and/or Dependent Care Assistance Plan to make an election to enroll in such Plan(s), and to allow an Eligible Employee who is currently enrolled in a Health Care Reimbursement

Plan and/or Dependent Care Assistance Plan to modify prospectively the amount (but not in excess of any applicable dollar limitation) of the employee's contributions to such Plan(s).

These amendments do not change the existing requirment that Health Care Reimbursement Plan amounts may be used only for Medical Care Expenses, and Dependent Care Assistance Plan amounts may be used only for Dependent Care Expenses.

ARTICLE II: GENERAL INFORMATION

Name of the Plan	State of New Mexico Flexible Spending Accounts
Name of Employer	State of New Mexico
Plan Administrator	State of New Mexico
Named Fiduciary & Agent for Service of Legal Process	State of New Mexico
Type of Administration	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the State of New Mexico Flexible Spending Accounts. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. The State of New Mexico 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 January 1 and December 31 of the same calendar year.
Code and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of the Code and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any

individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Fiduciary Liability

To the extent permitted by law, the Plan Administrator and other parties assuming a fiduciary or decision-making role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. The standard shall be one of Ordinary Care.

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 Reimbursement Plan
- Dependent Care Assistance Plan
- or elect to receive his or her entire compensation in cash.

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

3.2 HEALTH FSA BENEFITS

Upon proper election by a Participant in accordance with Section 3.3 herein, there shall be credited to each Participant's Health FSA Account any Benefit Credits that correspond to the Participant's Salary Reduction Agreement determined in accordance with Section 3.3 hereof. Such Health FSA Benefits shall not exceed the maximum amount allowable, as it may be revised by the Employer from time to time. The Participant's Health FSA Benefits shall be credited as and when such sum is redirected from the

Participant's compensation pursuant to the Salary Reduction Agreement then in effect. The Health FSA Benefits shall be used to pay all or part of the Health FSA Benefits that the Participant has designated pursuant to Section 3.3. The Health FSA Benefits paid on behalf of any Participant shall be a charge against the balance of his or her Health FSA Account.

3.3 ELECTION OF BENEFITS

Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or when Employee first becomes eligible, a Salary Reduction Agreement identifying the Health FSA Benefits and/or Dependent Care Assistance Benefits to be provided by the Employer to or on behalf of the Eligible Employee. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 8.4.

Each election under this Section 3.3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If an Eligible Employee separates from service with a Participating Employer during a period in which the employee is covered by a Benefit, the Employer may terminate the remaining portion of the Benefit coverage provided by the Plan. Any Participant or newly Eligible Employee who fails to execute an appropriate Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected cash compensation to the extent permissible.

3.4 NONDISCRIMINATION

Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Health FSA provided to Key Employees exceed 25% of the aggregate of such cost for the Health FSA provided to all Employees under the Plan. The Employer may limit or deny any Employee's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.5 EMPLOYER AND PARTICIPANT CONTRIBUTIONS

(a) **Employer Contributions.** The Employer may contribute a portion of the premium to fund Premium Conversion Plan benefits. There are no Employer contributions for the Health Care Reimbursement Plan or the Dependent Care Assistance Plan.

(b) **Participant Contributions.** The Employer shall withhold from a Participant's Compensation on a pre-tax Salary Reduction 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.

3.6 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 Reimbursement Plan or Dependent Care Assistance 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) **Contributions 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 to be Employer contributions.

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

3.7 FUNDING THIS PLAN

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Conversion Plan Benefits are paid as provided in the applicable insurance policy. 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, and 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 (except for Premium Conversion Plan Benefits paid as provided in the applicable insurance policy), 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 Premium Conversion Plan Benefits, and as described in the Health Care Reimbursement Plan and the Dependent Care Assistance 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.

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

4.2 PROCEDURE FOR AND EFFECT OF PARTICIPATION

An Eligible Employee may become a Participant in the Plan by executing a Salary Reduction Agreement under which the Employee agrees to reduce Compensation for the forthcoming Plan Year (or, if such Salary Reduction Agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year). The Salary Reduction Agreement shall be governed by Article 3. By becoming a Participant, each individual shall, for all purposes, be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

An Eligible Employee's spouse or dependents can not independently participate in the Plan.

4.3 TERMINATION OF PARTICIPATION

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) The expiration of the Period of Coverage and Grace Period, for which the Employee has elected to participate (unless the Employee elects to continue participating during the Open Enrollment Period for the next Plan Year);

(b) The termination of this Plan;

(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).

Termination of participation in the Plan will automatically revoke the Participant's elections and terminate the Premium Conversion Plan Benefits as of the date specified in the appropriate insurance Plan(s). Reimbursements from the Health Care Reimbursement Account and the Dependent Care Assistance Account after termination of participation will be made according to the individual plans.

4.4 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 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 before termination. If the Employer rehires a former Participant more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

4.5 FMLA LEAVES OF ABSENCE

Health and Dependent Care Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Care Reimbursement Account and Dependent Care Assistance Account 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 Reimbursement Account and Dependent Care Assistance Account during the leave. If the Participant elects to continue coverage while on unpaid FMLA leave, then the Participant shall pay his or her share of the premium.

Coverage will terminate if premium payments are not received by the due date established by the Employer. If a Participant's Health Care Reimbursement Account or Dependent Care Assistance 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 Reimbursement Account or the Dependent Care Assistance Account upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. A Participant whose coverage under the Health Care Reimbursement Account or the Dependent Care Assistance Account ceased will be entitled to elect whether to be reinstated in the Health Care Reimbursement Account or the Dependent

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

4.6 NON-FMLA LEAVES OF ABSENCE

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

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

4.7 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

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

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or
- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefit upon return from such leave on the

date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

4.8 DEFINITION OF "DEPENDENT" REVISED BY THE WFTRA OF 2005

The definition of “Dependent” has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA), effective January 1, 2005. An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

(a) The individual has a specific family type relationship to the taxpayer

(b) The individual does not provide more than half of his or her own support

(c) The individual has the same place of residence as the taxpayer for more than half of the year

(d) The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition, the following qualifying criteria apply to be considered a "dependent relative":

(a) The individual has a specific family type relationship to the taxpayer

(b) The individual is not a qualifying child of any other taxpayer

(c) The individual receives more than half of his or her support from the taxpayer

(d) The individual’s annual gross income is less than the Code Section 151 limit (this criteria does not apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)), at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee’s spouse are employed by Employer, dependent children may be covered by either spouse, but not by both.

NOTE: the Internal Revenue Service (the “IRS”) Notice 2010-38 (the “Notice”) provides important guidance regarding the tax treatment of employer-provided health coverage to employees’ adult children who have not attained age 27 as of the end of the employee’s taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage

for an employee's adult children and the amounts paid by (or reimbursed to) the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

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 of the month coincident with or next following the Administrator's receipt and approval of an Election Agreement signed by the Employee or the 1st of the month coincident with or next following 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 to each Employee who is eligible to participate in this Plan. The Election Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election 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.

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

If an Eligible Employee fails to file an Election Agreement within the time period 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.

However, a Participant who had previously elected any benefitsthrough the Premium Conversion Plan and who fails to file an Election Agreement with regard to a change in those benefits shall be deemed to

have elected the same benefits that he or she had at the end of the Plan Year preceding the Plan Year for which he or she failed to file an Election Agreement and to have agreed to a corresponding salary reduction for those benefits.

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 REIMBURSEMENT PLAN

6.1 BENEFITS

An Eligible Employee can elect to participate in the Health Care Reimbursement Plan by electing to receive benefits in the form of reimbursements for Medical Care Expenses (Health Care Reimbursement 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 Reimbursement Account is equal to the annual benefit amount elected by the Participant.

6.3 ELIGIBLE MEDICAL CARE EXPENSES

Under the Health Care Reimbursement Plan, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage and/or any applicable 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.

(b) **Medical Care Expenses**. Medical Care Expenses means expenses incurred by a Participant or Spouse or Dependents for medical care, as defined in Code §§213(d) and 106(f), other than expenses that are excluded by this Plan in (c) and (d) 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) **Monthly Limits on Reimbursing OTC Medical Care Items.** Only reasonable quantities of over-the-counter (OTC) medical care items of the same kind may be reimbursed from a Participant's account in a single calendar month. Stockpiling is not permitted.

(d) **Medical Expenses that are not reimbursable.** Insurance premiums; long-term care expenses are not reimbursable from the Health Care Reimbursement Plan; cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease; funeral and burial expenses; salary expense of a nurse to care for a healthy newborn at home; household and domestic help; custodial care; social activities such as dance lessons; cosmetics; toiletries; uniforms or special clothing, such as maternity clothing; marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician; any item that does not constitute an allowable expense.

6.4 MAXIMUM AND MINIMUM BENEFITS FOR HEALTH FSA.

(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) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 6.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 6.8. 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 Section 6 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 $2,750.00, subject to Section 6.5(c). The minimum 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 $10.00 per month, or $120 annually. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) **Changes; No Proration.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters

the Health FSA Module mid-year or wishes to increase his or her election mid-year as permitted under Section 8.4, 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 under Section 4 (other than under Section 4.5 for FMLA leave) that increases contributions to the Health FSA Module also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant 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 FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 4.5 for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) **Monthly Limits on Reimbursing OTC Medical Care Items.** Only reasonable quantities of over-the-counter (OTC) medical care items of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month; stockpiling is not permitted.

6.5 ESTABLISHMENT OF HEALTH FSA ACCOUNT.

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Module, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 6.6.

(a) **Crediting of Accounts.** A Participant's Health FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) **Debiting of Accounts.** A Participant's Health FSA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) **Available Amount Not Based on Credited Amount.** As described in Section 6.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit

amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, the absolute amount of which would not exceed the maximum dollar amount elected by the Participant under this Plan.

6.6 FORFEITURE OF HEALTH FSA ACCOUNTS; USE-IT-OR-LOSE-IT RULE.

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the Health FSA Module during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Notwithstanding the above, the Employer may also adopt up to a 2 ½ month grace period allowing an expense incurred in a new Plan Year to be reimbursed from unused funds of the prior Plan Year, or the Employer may amend the Plan to permit a carryover of up to $550.00 of a Participant's unused FSA account balance to the following Plan Year. The Employer may adopt either the 2 ½ month Grace Period option or the FSA Carryover option, but not both, and is required to inform Participants of the benefit before the end of the Plan Year to which it applies.

The Employer has adopted a 2 ½ month Grace Period allowing an expense incurred in a new Plan Year to be reimbursed from unused funds of the prior Plan Year, as provided in Subsection 6.6.1 of this document.

6.6.1. UNUSED YEAR END BALANCE; GRACE PERIOD.

If any balance remains in the Participant's Health FSA Account after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year, other than during the Grace Period.

The Grace Period shall begin immediately following the end of the Plan Year and terminate on the fifteenth day of the third calendar month after the end of the Plan Year. If a balance remains in the Participant's Health FSA 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 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); and (b) to increase the Employer's general revenues consistent with applicable regulations. In addition, any Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage and/or any applicable Grace Period in which the health care expense was incurred shall be applied as described above.

6.7 REIMBURSEMENT CLAIMS PROCEDURE FOR HEALTH FSA.

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

(b) **Claims Substantiation.** An independent third party designated as the PHI Officer will substantiate all claims. A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the PHI Officer in such form as the Plan Administrator may prescribe, by no later than the 90 days following the close of the Plan Year (plus any Grace Period) in which the Medical Care Expense was incurred (except for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 6.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;

- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- as of January 1, 2011, a prescription from the Participant's physician for any OTC drugs and medicines (e.g., Advil, ibuprofen, cough syrup); and
- other such details about the Expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., 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 showing the amounts of such Expenses, along with any additional documentation that the PHI Officer may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $10. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with IRS guidance.

(c) **Claims Denied.** For reimbursement claims that are denied, see the appeals procedure in Section 11.2.

6.8 REIMBURSEMENTS FROM HEALTH FSA AFTER TERMINATION OF PARTICIPATION; COBRA.

When a Participant ceases to be a Participant under Section 2.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage or Grace Period prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Module because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Module the day before the qualifying event for the periods prescribed by

COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 6.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for

the Health FSA Module will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

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

6.9 DEBIT CARDS

New proposed regulations incorporate previous guidance on the use of a debit card to pay, substantiate and reimburse qualified expenses.

(a) Before a Participant receives a health FSA debit card s/he must agree in writing to the following:

  (1) That the debit card will only be used to pay for medical expenses (as defined by Code section 213(d)) of the employee, spouse and/or dependent;

  (2) That the debit card will not be used for expenses that have already been reimbursed;

  (3) That s/he will not seek reimbursement under any other health plan for any expense paid with the debit card; and

  (4) That s/he will acquire and retain sufficient documentation to substantiate any expense paid with the debit card.

(b) The debit card must contain a statement providing that the above provisions have been agreed to in writing, and are reaffirmed each time the employee uses the card.

(c) The amount available must equal the employee's annual election (uniform coverage rule applies), and is reduced by amounts paid or reimbursed for medical expenses incurred during the year.

(d) The card will be automatically cancelled when the employee ceases participation in the Plan.

(e) The Plan Administrator limits the use of the debit card to:

(1) Medical Care Providers (physicians, dentists, hospitals, etc.);

(2) Stores with merchant category codes (MCC) for drugstores and pharmacies if such stores meet the 90% gross receipts test for items that qualify as Code section 213(d) expenses; and

(3) Stores that have implemented the inventory information approval system (IIAS).

Please Note: Plan Administrator may limit the use of the debit card to IIAS Merchants to avoid debit card use for ineligible OTC items.

(f) The Employer substantiates claims in compliance with the regulations.

(g) The Plan Administrator will follow proper correction procedures for improper payments as outlined in IRS proposed regulations.

New regulations permit substantiation for expenses that are copay matches (exact multiples of five or fewer), recurring expenses and real-time substantiation. The proposed regulations permit point-of-sale substantiation when the inventory information approval system matches the expense with a list of Code § 213(d) expenses. The Plan Administrator is responsible to ensure that the inventory information approval system meets the requirements of the new regulations.

ARTICLE VII: DEPENDENT CARE ASSISTANCE PLAN

7.1 BENEFITS

An Eligible Employee can elect to participate in the Dependent Care Assistance Plan by electing to receive benefits in the form of reimbursements for Dependent Care Expenses (Dependent Care Assistance 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.

7.2 BENEFIT PREMIUMS

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

7.3 ELIGIBLE DEPENDENT CARE EXPENSES

Under the Dependent Care Assistance Plan, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage and/or any applicable Grace Period 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 Assistance Plan can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.

(c) **Qualifying Individual.** Qualifying Individual means:

(1) A Participant's Dependent who is under the age of 13;

(2) A Participant's Dependent who is mentally or physically incapable of self-care; or

(3) A Participant's Spouse who is mentally or physically incapable of self-care.

(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 DCAP and during the Period of Coverage and Grace Period; 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; or

ii. The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household. In addition, if the expenses are incurred for

services provided by a facility that provides care for more than 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; or

(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.

(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 and any applicable Grace Period) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's Dependent Care Assistance Account less amounts debited to the Participant's Dependent Care Assistance 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 and/or any applicable Grace Period 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 or,

(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); provided that, in accordance with the authority granted by the Internal Revenue Serivce pursuant to the American Rescue Plan Act of 2021 and other Federal laws, this Plan is amended to increase the annual limits for pretax contributions to $10,500 (up from $5,000) for single taxpayers and married couples filing jointly, and to $5,250 (up from $2,500) for married individuals filing separately. The higher limits apply only to the Plan Year beginning after Dec. 31, 2020 and before Jan. 1, 2022.

. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $130.00.

7.5 ESTABLISHMENT OF ACCOUNT

The Plan Administrator will establish and maintain a Dependent Care Assistance Account with respect to each Participant who has elected to participate in the Dependent Care Assistance 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 Section7.6.

(a) **Crediting of Accounts.** A Participant's Dependent Care Assistance 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 Assistance Account will be debited during each Period of Coverage and/or any applicable Grace Period for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage and/or any applicable Grace Period.

(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 Assistance Account, less any prior reimbursements.

(d) **Effect on Maximum Benefits if Election Change Permitted**. Any change in an election affecting annual contributions to the Dependent Care Assistance Plan also will change the maximum reimbursement benefits for the balance of the Period of Coverage and/or any applicable Grace Period (commencing with the election change effective date), as further limited above. Such maximum reimbursement benefits for the balance of the Period of Coverage and/or any applicable Grace Period shall be calculated by adding (1) the aggregate premium for the period prior to such election change to (2) the total premium for the remainder of such Period of Coverage to the Dependent Care Assistance Account, reduced by (3) reimbursements during the entire Period of Coverage.

7.6 UNUSED YEAR END BALANCE; GRACE PERIOD.

If any balance remains in the Participant's Dependent Care Assistance 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, other than during the Grace Period.

The Grace Period shall begin immediately following the end of the Plan Year and terminate on the fifteenth day of the third calendar month after the end of the Plan Year. If a balance remains in the Participant's Dependent Care Assistance Account upon completion of the Grace Period such amount shall not be carried over to reimburse the Participant for Dependent 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 reduce the cost of administering the Dependent Care Assistance Plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and (b) to increase the Employer's general revenues consistent with applicable regulations. In addition, any Dependent Care Assistance Plan benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage and/or any applicable Grace Period 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 Plan 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 Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete and incomplete reimbursement claim.

(b) **Claims Substantiation.** A Participant who has elected to receive Dependent Care Assistance Plan Benefits for a Period of Coverage may apply for reimbursement by completing, signing, and returning an application to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than a date set each year by the Plan Administrator which such date shall not be earlier than March 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 so 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; and

(5) A statement that such Expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source.

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

(c) **Claims Denied.** For reimbursement claims that are denied, see the Section 9.2.

7.8 REIMBURSEMENTS AFTER TERMINATION

When a Participant ceases to be a Participant, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements, subject to the following: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage or Grace Period prior to termination, including expenses incurred during the Plan Year

following termination, provided that the Participant (or 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 Plan 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 Assistance Plan, as the Plan 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 60 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 of the month coincident with or next following the event and the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the 1st of the month coincident with or next following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable Benefit Package Option commences later).

(c) **Changes; No Proration.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Agreement or another document. If a Participant enters the Dependent Care Assistance Plan or the Health Care Reimbursement 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 Reimbursement Plan or the Dependent Care Assistance Plan also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (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 Reimbursement Plan or the Dependent Care Assistance Plan, reduced by (3) all reimbursements made during the entire Period of Coverage.

8.3 CHANGE IN STATUS DEFINED

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

(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 Assistance Plan, a change in the number of qualifying individuals as defined in Code § 21(b)(1);

(c) **Employment Status.** Any of the following events that change the employment status of the Participant (as limited by Section 4.3) or 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; and

(5) If the eligibility conditions of this Plan or other employee benefit Plan of the Participant or Spouse or Dependents 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 other employee benefit Plan, such as 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, such as 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 or Spouse or Dependents.

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** (Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits). A Participant may change an election during the Open Enrollment Period.

(b) **Termination of Employment** *(Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits).* A Participant's election will terminate upon termination of employment.

(c) **Leaves of Absence** (Applies to Premium Conversion Plan, Health Care Reimbursement Plan and Dependent Care Assistance Plan Benefits). A Participant may change an election upon leave as described in Article IV.

(d) **Change in Status** (Applies to Premium Conversion Plan, Health Care Reimbursement Plan as limited below and Dependent Care Assistance Plan as limited below). 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 is made on account of and 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 by that Change in Status that affects eligibility for coverage (referred to as the general consistency requirement).

A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer 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 from a Spouse, 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 or Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) **Certain Judgments, Decrees and Orders** *(Applies to Premium Conversion Plan and Health Care Reimbursement Plan).* If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health Care Reimbursement 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 Premium Conversion Plan and Health Care Reimbursement Plan).* If a Participant or Spouse or Dependent who is enrolled in a health or accident plan under this Plan 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 Reimbursement coverage) of the person becoming entitled to Medicare or Medicaid. Further, if a Participant or 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 Reimbursement coverage) of the individual who loses Medicare or Medicaid eligibility.

(g) **Change in Cost** *(Applies to Premium Conversion Plan and Dependent Care Assistance Plan 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 Plan 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 Plan Administrator, on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(2) **Insignificant Cost Increases.** Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for the benefits and to decrease their elective contributions to reflect insignificant decreases in the required contribution. The Plan Administrator on a uniform and consistent basis will determine whether an increase or decrease is insignificant based on all the surrounding facts and circumstances, including but not limited to, the dollar amount or percentage of the cost change. The Plan Administrator

on a reasonable consistent basis will automatically make this increase or decrease in affected Employees' elective contributions on a prospective basis.

(3) **Limitation on Change in Cost Provisions for Dependent Care Assistance Benefits**. The above Change in Cost provisions apply to Dependent Care Assistance 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 related as described in Code § 152(a)(1) through (8), incorporating the rules of Code § 152(b)(1) and (2).

(h) **Change in Coverage** *(Applies to Premium Conversion Plan and Dependent Care Assistance 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 Plan 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 Plan 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 so as to constitute reduced coverage generally.

(3) **Significant Curtailment with a Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit 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 Premium Conversion Plan and Dependent Care Assistance Benefits).* If during a Period of Coverage, the Plan adds a new Benefit Plan or significantly improves an existing Benefit Plan, the Plan 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 Article IV 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 Plan 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) **Loss of Coverage Under Other Group Health Coverage** *(Applies to Premium Conversion Plan Benefits).* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(k) **Change in Coverage Under Another Employer Plan** *(Applies to Premium Conversion Plan and Dependent Care Assistance 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 other than this section; 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 Plan Administrator, on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(l) **Dependent Care Assistance Plan Coverage Changes** *(Dependent Care Assistance 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.

(3) 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 Plan 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 Plan 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 other 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 Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction

amount, 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: CLAIMS

9.1 CLAIMS UNDER THE PLAN

If a claim for reimbursement under the Health Care Reimbursement Plan or Dependent Care Assistance 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 procedure established by the Plan Administrator for this Plan will apply.

9.2 PROCEDURE IF BENEFITS ARE DENIED UNDER THIS PLAN

Claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to appeal the denial. The rules regarding denied claims for benefits under the Health Expense FSA are set forth, according to ERISA guidelines, in the **Questions and Answers** section of this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

ARTICLE X: GLOSSARY

Administrator means State of New Mexico.

Benefits means the Premium Conversion Plan Benefits, the Health Care Reimbursement Plan Benefits and the Dependent Care Assistance 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 means any individual who is a tax dependent of the Participant as defined in Code §§105(b) and 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Conversion Plan, and for purposes of the Health Care Reimbursement Plan), a dependent is defined as in Code §§105(b) and 152, determined without regard to §152 subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents; and (b) for purposes of the Dependent Care Assistance Plan, a dependent means a qualifying individual as defined in Code §21(b)(1) with respect to the Participant, and in the case of divorced parents, the child shall, as provided in Code §21(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code §152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health Care Reimbursement Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent Care Expenses has the meaning described in Dependent Care Assistance 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 Health Care Reimbursement Plan or Dependent Care Assistance 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 has the meaning described in Introduction.

Election Agreement means the form provided by the Plan Administrator or the Internet web site and procedures used for the purpose of allowing an Eligible Employee to participate in this Plan by electing 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 Eligibility and Participation.

Employee Means an individual that the State of New Mexico classifies as a common-law employee and who is on State of New Mexico'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 the State of New Mexico.

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

Grace Period means a period of time as specified by the Employer in which qualified Medical Care Expenses and qualified Dependent 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. Except as otherwise provided in the Plan, 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.

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

Medical Care Expenses has the meaning defined in Health Care Reimbursement Plan.

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

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Eligibility and Participation. Participants include (a) those who elect one or more of the Premium Conversion Plan Benefits, Health Care Reimbursement Benefits, or Dependent Care Assistance Benefits, and Salary Reductions to pay for such Benefits; and (b) those who elect instead to receive their full salary in cash and to pay for their share of their premiums under the Premium Conversion Plan (if any) with after-tax dollars outside of this Plan and who have not elected any Health Care Reimbursement or Dependent Care Assistance 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 Eligibility and Participation; 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 Eligibility and Participation.

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

Plan Year means the twelve-month period between January 1 and December 31 of the same calendar year.

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

Premium Conversion Benefit Plan means the self-insured health benefit plan provided to all state employees.

Protected Health Information (PHI) means information that is created or received by the State of New Mexico Flexible Spending Accounts and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. 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 Assistance Plan.

Qualifying Individual has the meaning described in the Dependent Care Assistance Plan.

Related Employer means any employer affiliated with State of New Mexico that, under Code §414(b), (c), or (m), is treated as a single employer with State of New Mexico 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 Assistance 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, file 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 each of 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.

ARTICLE XI: RECORD KEEPING AND ADMINISTRATION

11.1 PLAN ADMINISTRATOR

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

11.2 POWERS OF THE PLAN ADMINISTRATOR

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters there under, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan 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, notwithstanding the first paragraph in this Section 11.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 11.1; (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 Plan Administrator determines to be appropriate; (d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan; (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan; (f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper; (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 it deems 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.

11.3 RELIANCE ON PARTICIPANT, TABLES, ETC.

The Plan 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 Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

11.4 PROVISION FOR THIRD-PARTY PLAN SERVICE PROVIDERS

The Plan Administrator may employ the services of such persons as it may deem 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 Plan Administrator.

11.5 FIDUCIARY LIABILITY

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

11.7 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.

11.8 INABILITY TO LOCATE PAYEE

If the Plan 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.

11.9 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 Plan Administrator shall, to the extent it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued there under, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XII: GENERAL PROVISIONS

12.1 EXPENSES

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 6.6 and 7.6, and then by the Employer.

12.2 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 of time. All Employees are considered to be employed at the will of the Employer.

12.3 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 Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

12.4 EFFECT OF PLAN ON EMPLOYMENT

The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

12.5 ALIENATION OF BENEFITS

No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA.

12.6 FACILITY OF PAYMENT

If the Employer deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Employer.

12.7 PROOF OF CLAIM

As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Employer may require (either directly to the Employer or to any person delegated by it).

12.8 STATUS OF BENEFITS

The Employer believes that this Plan is written in accordance with section 105 of the Code and that it provides certain benefits to Employees which are free from Federal income tax under the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

12.9 GOVERNING LAW

This Plan shall be construed, administered and enforced according to the laws of the State of New Mexico, to the extent not superseded by the Code or any other federal law.

12.10 CODE COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code 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 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.

12.11 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the Employer makes 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 Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

12.12 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.

12.13 NON-ASSIGNABILITY OF RIGHTS

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

12.14 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 construction of any provision.

12.15 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.

12.16 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.

12.17 HEIRS AND ASSIGNS

This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

12.18 GENDER AND FORM

Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

12.19 MULTIPLE FUNCTIONS

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

12.20 SOURCE OF PAYMENTS

The Employer shall be the sole source of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the State of New Mexico upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

ARTICLE XIII: COMPLIANCE WITH HIPAA

It is intended that this Plan meet all applicable requirements of the Health Insurance Portability and Accountability Act (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.

13.1 USE OF PROTECTED HEALTH INFORMATION (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (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 protected health information 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 the obtaining of generalized 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 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 policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, 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 law and as permitted by authorization of the participant or beneficiary. 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 administrations functions.

(1) Any employee responsible for establishing and maintaining employee deduction and reduction records for the Employer,

(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.

13.2 PRIVACY OFFICIAL

The Privacy Official shall be responsible for compliance with the Health FSA's obligations under this Section 7 and HIPAA. Specific rules regarding the Privacy Official follow:

(a) **Appointment, Resignation and Removal of Privacy Official.** The Employer shall appoint one or more individuals to act as Privacy Official on matters regarding the Health FSA. The individual appointed as Privacy Official may resign by giving 30 days notice in writing to the Employer. The Employer shall have the power to remove that individual for any or no reason.

(b) **Policies and Procedures.** The Privacy Official and the Plan Administrator shall from time to time formulate such policies and procedures as they deem necessary for the Health FSA's compliance with this Article and HIPAA. No policy or procedure, however, shall amend any substantive provision of the Health FSA.

(c) **Privacy Notice.** The Privacy Official shall be responsible for arranging with the Employer, the Plan Administrator, and any third-party administrator for the issuance of, and any changes to, the Privacy Notice under the Health FSA.

(d) **Complaint Contact Person.** The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the Health FSA HIPAA Privacy Notice.

13.3 HIPAA SECURITY RULE

The Employer, as the Plan sponsor, shall comply with the plan document requirements of the HIPAA security regulations found at 45 CFR § 164.314(b).

(a) **Electronic Protected Health Information.** "Electronic Protected Health Information" shall mean individually identifiable health information that is transmitted by electronic media or maintained in electronic media by the Plan.

(b) **Employer Agreement.** The Employer agrees to:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transits on behalf of the Plan.

(2) Ensure that the adequate separation between the Plan and the Employer as required by the Privacy Rule is supported by reasonable and appropriate security measures.

(3) Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Heath Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information; and

(4) Report to the Plan Administrator any security incident of which it becomes aware.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the State of New Mexico Flexible Spending Accounts, State of New Mexico has caused this Plan to be executed in its name and on its behalf, on this 19th day of October, 2021.

State of New Mexico

By: _____

State of New Mexico Director of Risk Management

Witness Signature: _____.

APPENDIX A

Related Employers That Have Adopted This Plan,
With the Approval of State of New Mexico.

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