

HealthFlex Plan

A Program of Group Health Care Plans, Cafeteria and Flexible Spending Account Plans, Health Reimbursement Accounts, and Other Benefits

Effective January 1, 2026

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Article I – General Purpose

1.01 History. This Plan is an amendment and restatement of the HealthFlex Plan, formerly called the Hospitalization and Medical Expense Program, including added and revised provisions, effective January 1, 2026. The Plan was most recently amended and restated to reflect the name change of The General Board of Pension and Health Benefits of The United Methodist Church to Wespeth, the transfer of the Plan Trustee role from UMC Benefit Board, Inc. to Wespeth, and other clarifying changes. The Plan was established as a welfare benefit program for clergy and lay employees of The United Methodist Church effective January 1, 1961. The Plan was previously amended and restated in 1994, 2007, 2014, and 2022.

1.02 The Plan. The Plan consists of this Plan document, the Plan’s *Summary Plan Description*, and any applicable Coverage Document listed in Appendix A hereto, which, by this reference, are incorporated herein. To the extent that the *Summary Plan Description* or a Coverage Document conflicts with this Plan document, this Plan document shall control. The Plan will apply to a Participant, Disabled Participant, Retired Participant, Terminated Participant, or a covered Dependent as of the date such person first became eligible for the Plan. Claims for benefits incurred before this effective date must be submitted under the provisions of the Plan in effect on the date the claim was incurred.

1.03 Nature of Plan. The Plan is intended to be a program of one or more church-sponsored employee welfare benefit plans within the meaning of ERISA §3(1), and an instrumentality of Wespeth, to be administered for purposes consistent with responsibility and authority provided for in paragraph 1501 *et seq.* of *The Book of Discipline* of The United Methodist Church. Plan Sponsors may or may not be Affiliates of one another. For the purpose of Code §414(e), the Plan Sponsors are each intended to be a church, a convention or association of churches (within the meaning of Code §414(e)(3)(C)), or an organization controlled by or associated with a church or a convention or association of churches (within the meaning of Code §414(e)(3)(D)). Accordingly, the Plan Sponsors are intended to be one employer for the purpose of Code §414(e). Further, the Plan is intended to meet the requirements of a “church plan” as that term is defined in Code §414(e) and ERISA §3(33), and to be exempt from ERISA as a Church Plan to the extent permitted under Code §410(d) and ERISA §4(b)(2), and any other applicable law. As a Church Plan, the Plan is also intended to be exempt from COBRA continuation coverage requirements pursuant to Code §4980B(d) and Treasury Regulations §54.4980 B-2, Q. and A. No. 4. For the purpose of the Medicare Secondary Payer rules, the Plan is intended to be a multiple employer group health plan whose participating and electing small employers, for which the Plan has submitted and may continue to submit an election to the Centers for Medicare and Medicaid Services, are exempt from the Medicare Secondary Payer rules under §1862 of the Social Security Act at 42 U.S.C. §1395y(b)(1)(A)(iii).

Moreover, generally, the Plan is intended to be administered as a “cafeteria plan” as that term is defined in Code §125(d). As a cafeteria plan, the Plan allows eligible Employees the opportunity to make contributions from their compensation to pay the cost of certain Benefit Options offered by Wespeth and participating Plan Sponsors and to make contributions from their compensation to a Health Savings Accounts linked with high-deductible health plans as permitted under Code §125(d)(2)(d) and §223, and to receive eligible medical expense reimbursement and dependent care expense reimbursement on a before-tax basis, as permitted

under Code §105 and §129. The Plan shall not provide for any deferred compensation of any nature; provide for any benefit that defers the receipt of compensation; or operate in a manner that enables Participants to defer the receipt of compensation.

The Plan is a multiple employer church health plan for the purposes of the fees related to the Patient-Centered Outcomes Research Institute (PCORI) established under §6301 of the PPACA, which added Code §4376. As such, the Plan Administrator shall pay the PCORI fees applicable to Plan Participants and other covered lives, e.g., Dependents, in accordance with the PPACA and applicable regulations. The Plan Administrator shall act as “plan sponsor” with respect to the PCORI fees and remit payment of such fees to the Internal Revenue Service or Department of Health and Human Services on behalf of all participating Plan Sponsors and their covered employers (Salary-Paying Units). Because the Plan is a multiple employer health plan maintained by a Plan Administrator whose primary purpose is providing employee benefits, the PCORI fees shall be paid from the assets of the Plan.

1.04 Defined Terms. As used in this Plan, capitalized terms, including acronyms, have the meanings set forth in Article II. When not set forth in that Article or another Article, capitalized terms have the meanings set forth in predecessor plans or the meanings given to them in *The Book of Discipline*, or applicable laws or regulations.

1.05 Funding. Required Contributions to fund the benefits provided under the Plan are made by the Plan Sponsors and Participants as provided in the Plan.

(a) ***The Trust.*** To receive such Required Contributions, Wespath has established the Trust pursuant to the Trust Agreement. All benefits under the Plan will be provided exclusively by distributions from the Trust. The Trustee has the powers and duties specified in the Trust Agreement. Wespath has the authority to replace the Trustee of the Trust at any time, or to establish additional Trusts to fund benefits under the Plan.

(b) ***Insurance Contracts.*** Benefits under the Plan may also, at Wespath’s discretion, be provided by the purchase of insurance contracts, and, in such event, the term Trust will also include the Plan’s interest, if any, in such insurance contracts. Such insurance contracts may be entered into by Wespath. Under the terms of any insurance contract issued for a Benefit Option, the insurance company issuing the contract has full discretionary authority to make all benefit decisions concerning entitlement to benefits under the contract, payment of claims or benefits, and interpretation of the terms of the insurance contract. Its decisions are final and binding on all parties. The Plan Administrator does not guarantee the payment of any benefit described in an insurance coverage contract and a Participant or beneficiary, as applicable, must look solely to the insurance carrier for the payment of benefits.

1.06 Plan Sponsors.

(a) ***Eligible Entities.*** Subject to the limitations of Code §414(e)(2) and subsection (b) below, any of the following entities that is eligible to participate in an employee welfare benefit plan that is a Church Plan and satisfies the Plan’s underwriting requirements is eligible to execute an Adoption Agreement to be a Plan Sponsor under the Plan:

- (i) An entity that is:
 - (A) controlled by or associated with The United Methodist Church or an autonomous affiliated church; and
 - (B) a Code §501(c)(3) organization or a self-employed minister within the meaning of Code §414(e)(5)(A)(i)(I).
- (ii) An entity:
 - (A) that does not satisfy paragraph (a)(i); but
 - (B) that pays one or more Clergypersons who are Under Episcopal Appointment, or appointed by a Disaffiliated Church, to such entity; and
 - (C) that sponsors the Plan with respect to any such Clergyperson who qualifies under Code §414(e)(3)(B)(i), even though The United Methodist Church or a Disaffiliated Church is deemed to be such Clergyperson's employer under Code §414(e)(3)(C). Notwithstanding the foregoing, any such Clergyperson will be treated as a Clergy Employee of the Plan Sponsor for the purposes of this Plan.
- (iii) An entity described in Code §414(e)(2), provided that the Plan Administrator determines that the number of Participants covered by such Plan Sponsors meets the limits of Code §414(e)(2).

No other entity may be a Plan Sponsor of the Plan.

- (b) **Covered Employees.** Plan Sponsors who qualify under Section 1.06(a) above may execute an Adoption Agreement with respect to the following types or classes of Employees:
 - (i) Lay Employees;
 - (ii) Clergy Employees; and
 - (iii) Retired Employees.

Subject to rules adopted by the Plan Administrator and the coverage and nondiscrimination requirements of the Code and Treasury Regulations, a Plan Sponsor may execute more than one Adoption Agreement covering different classifications of Employees.

1.07 Adoption of the Plan. An eligible Plan Sponsor may adopt the Plan in accordance with Article XIV and the terms of an Adoption Agreement. A Plan Sponsor may discontinue sponsoring the Plan in accordance with Article XIV and the terms of its Adoption Agreement.

1.08 Risk Pool Rules. Wespath may establish and enforce eligibility, participation and coverage rules for mitigating adverse selection risk and moral hazard, spreading the risk of large claims

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among Plan Sponsors, and reflecting the connectional nature of the denomination. Wespeth staff may establish and amend, from time to time, various risk pools for Plan Sponsors, among other mechanisms for managing risk, and may amend the rules from time to time. The risk pool rules established by Wespeth may vary between Conference Plan Sponsors and other Plan Sponsors; among Conference Plan Sponsors; and between Clergy Employees and Lay Employees. The risk pool rules established by Wespeth are hereby incorporated by reference.

Article II – Definitions

Each word and phrase defined in this Article II shall have the following meaning whenever such word or phrase is capitalized and used herein, unless a different meaning is clearly required by the context of the Plan. The definition of any term herein in the singular may also include the plural.

- 2.01 Account.** The individual account or accounts established by the Plan Administrator under Article IV in the name of each Participant for the purpose of accounting for Contributions allocated to and benefits paid for a Participant.
- 2.02 Active Conference Member.** A Clergy person who is not a Terminated or Retired Conference member.
- 2.03 Active Employee.** A Clergy Employee or Lay Employee who is not a Disabled Employee, Retired Employee, or on a Leave of Absence and has not had a Termination of Employment. Notwithstanding the foregoing, a Retired Employee who continues to work for a Plan Sponsor or Salary-Paying Unit, i.e., has “current employment status” with the Plan Sponsor or Salary-Paying Unit as described in the Medicare Secondary Payer Rules, shall be treated as an Active Employee for purposes of this Plan.
- 2.04 Adoption Agreement.** An agreement executed by each Plan Sponsor and accepted by the Plan Administrator that is a part of this Plan and is the means by which a Plan Sponsor adopts the Plan and specifies any optional provisions, such as optional categories of eligibility and Benefit Options, which are a part of any Plan as to that Plan Sponsor.
- 2.05 Affiliate.** Any entity that is:
- (a) a corporation that is a member of the same controlled group of corporations, as defined in Code §414(b), as a Plan Sponsor;
 - (b) a trade or business, whether or not incorporated, that is under common control with a Plan Sponsor within the meaning of Code §414(c);
 - (c) a member of the same affiliated service group, as defined in Code §414(m), as a Plan Sponsor; or
 - (d) otherwise required to be aggregated with a Plan Sponsor pursuant to Regulations issued under Code §414(o), but that is not itself a Plan Sponsor.
- 2.06 Annual Election and Enrollment Period.** A period, usually 2-3 weeks in the fall immediately preceding a Plan Year, as prescribed by the Plan Administrator.
- 2.07 Appoint or Appointment.** Officially appointed by a Bishop to a ministry pursuant to ¶425-¶430 of *The Book of Discipline*.
- 2.08 Associate Member.** A person elected to associate membership in an Annual Conference within the meaning of ¶321 or ¶322 of *The Book of Discipline*.

- 2.09 Benefit Option.** A Plan Sponsor's arrangements to provide medical, dental, vision and other Benefit Options to Employees and their dependents and beneficiaries, as listed in Exhibit B to its Adoption Agreement, as amended from time to time. A list of Benefit Options available under the Plan as of the effective date of this restatement is attached hereto as Appendix A. Wespath, in its sole discretion, may add or delete Benefit Options at any time. Moreover, Wespath may also modify the terms of any Benefit Option to comply with applicable law and regulations, including, but not limited to the PPACA, PHSa and the Code.
- 2.10 Bishop.** A bishop of The United Methodist Church elected by a Jurisdictional Conference in accordance with ¶405 of *The Book of Discipline* and continuing to serve under Section III of Chapter Three of Part VI of *The Book of Discipline*.
- 2.11 *The Book of Discipline.*** *The Book of Discipline of The United Methodist Church 2020/2024*, the body of church law as established by General Conference, as amended and restated from time to time. Cited paragraphs or other subdivisions are deemed to refer to successor provisions when an amendment or restatement of *The Book of Discipline* causes a change in location or citation.
- 2.12 Change in Status.** An occurrence of any of the events described in Section 5.07(b), as well as any other events included under subsequent changes to §125 of the Code or regulations issued thereunder, which Wespath, in its sole discretion and on a uniform and consistent basis, determines are permitted under the Treasury Regulations.
- 2.13 Church Plan.** An employee benefit plan established and maintained for its employees by a church or by a convention or association of churches as established in §414(e) of the Code and §3(33) of ERISA. Church plans are exempt from the requirements of Title I of ERISA by §4(b)(2) of ERISA and from COBRA continuation requirements by §4980B(d) of the Code and §54.4980 B-2, Q. and A. No. 4 of the Treasury Regulations.
- 2.14 Claim.** A Claim is notification in a form acceptable to the Plan Administrator, Claim Administrator, or Recordkeeper that a service has been rendered or furnished to a Participant and a request for payment or reimbursement of charges for the service has been made. The Claim must include full details of the service received, including a Participant's name, identification number, other demographic or identifying information, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the charge and any other information that the Plan Administrator, Claim Administrator, or Recordkeeper may request.
- 2.15 Claim Administrator.** A third-party administrator to whom the Plan Administrator has delegated administrative duties under the Plan. Claim Administrators are generally engaged through contracts or agreements to perform administrative functions for the Plan, including, but not limited to, processing Claims for benefits hereunder, providing access to a network of health care providers, paying Claims, hearing appeals and communicating with Participants. Some Claim Administrators may be engaged as Insurers of certain benefits provided under the Plan through the execution of contracts and the purchase of insurance policies by the Plan or the Plan Administrator. The Plan Administrator may also delegate certain fiduciary duties to a Claim Administrator through an agreement, contract or insurance

policy.

2.16 Claimant. A Participant or Dependent who makes a Claim for benefits under the Plan or who appeals the denial of such a Claim, or such person's representative.

2.17 Clergy Employee. An Employee who is:

- (a) a Clergy person who is an Active Conference Member and Under Episcopal Appointment to, or on a Leave of Absence from, a Plan Sponsor;
- (b) a Bishop; or
- (c) a clergy person who is employed by a Disaffiliated Church.

2.18 Clergy person. One of the following persons who is not a Bishop:

- (a) an Elder in Full Connection;
- (b) a Deacon in Full Connection;
- (c) a Local Pastor;
- (d) a Provisional Member;
- (e) an Associate Member;
- (f) a clergy person of another denomination within the meaning of ¶346.1 or ¶346.2 of *The Book of Discipline*; or
- (g) a clergy person who is employed by a Disaffiliated Church.

With respect to such Clergy persons under section (g), the terms of the Plan will be interpreted by the Plan Administrator in a manner that it deems reasonable and appropriate under the circumstances; for example, definitions that apply only to Clergy persons of The United Methodist Church (such as "Under Episcopal Appointment", "Conference", or *The Book of Discipline* definitions) will be deemed inapplicable to Clergy persons of a Disaffiliated Church, and will instead be interpreted in a manner that is reasonable and appropriate in that context.

2.19 Code. The Internal Revenue Code of 1986, as amended from time to time, and any regulation, ruling, or other administrative guidance issued pursuant thereto by the Internal Revenue Service.

2.20 Coverage Document. The applicable benefits booklet, insurance contract or policy document, and/or other written documents listed in Appendix A hereto pursuant to which benefits of the Plan are provided.

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2.21 Compensation. The sum of the following:

- (a) the cash salary received by the Participant from the Salary-Paying Unit and Plan Sponsor;
- (b) the housing allowance, if any, determined in accordance with the provisions of the Clergy Retirement Security Program, as amended, or the United Methodist Personal Investment Plan, as amended;
- (c) any salary-reduction contribution to a pension program administered by the General Board; and
- (d) any Employee Contributions under Section 4.05(a) herein, on a Participant's behalf.

2.22 Conference. Any Annual Conference, Provisional Conference, or Missionary Conference that is described in *The Book of Discipline* and is located in a Jurisdictional Conference.

2.23 Contribution. A Plan Sponsor Contribution or a Participant Contribution.

2.24 Deacon in Full Connection. A member of the Order of Deacons within the meaning of ¶328-¶331 of *The Book of Discipline* who is a member of a Conference and not a Provisional Member.

2.25 Dependent. For purposes of coverage under a Benefit Option, Dependent shall have the meaning defined in such Benefit Option. Dependent also may include, for Plan Sponsors who so elect through an Adoption Agreement, a same sex partner joined in a civil union or a domestic partnership, which, under the law of the state in which the Employee resides, provides the same substantive and procedural rights, privileges, and immunities as marriage. The Plan Administrator may request and require satisfactory proof of Dependent status at any time and from time-to-time as a condition of receiving coverage under the Plan.

2.26 Dependent Care FSA. A dependent care reimbursement program, i.e., a dependent care flexible spending account arrangement, established by the Plan Administrator in accordance with Article VIII.

2.27 Disabled. Any of the following with respect to an Employee:

- (a) determined to be disabled by the Social Security Administration;
- (b) being disabled under the terms of the Comprehensive Protection Plan, Basic Protection Plan, or UMLifeOptions Plan, as amended from time to time, or a successor plan; or
- (c) being determined to be disabled by the Plan Administrator or its agents on the basis of objective medical evidence that the Employee is unable to perform the usual and customary duties of his or her employment by reason of bodily injury, disease, or mental or emotional disease or disorder which will presumably last for at least six months, exclusive of any disability resulting from: (1) service in the armed forces of

any country, (2) warfare, (3) intentionally self-inflicted injury, or (4) participation in any criminal or unlawful act.

After having been covered as a Disabled Participant for 24 months, the Participant shall continue to be considered Disabled only if such Participant is unable to engage in any occupation for which such Participant is reasonably qualified by training, education, experience, or age. In order to continue coverage after 24 months as a Disabled Participant, the Participant will be required to submit medical evidence of such ongoing disability to the Plan Administrator.

- 2.28 Disaffiliated Church.** A local church or group of churches that has disaffiliated from The United Methodist Church under the provisions of ¶2553 of *The Book of Discipline* (which became effective at the close of 2019 General Conference and expired on December 31, 2023), or has changed its connectional relationship pursuant to ¶2547, ¶2548, or ¶2549 of *The Book of Discipline* or otherwise but retains common religious bonds and convictions with The United Methodist Church based on shared Wesleyan theology and tradition and Methodist roots.
- 2.29 Early Retirement Age.** The age or service completion date specified in ¶358.2b of *The Book of Discipline*; or, for a person who retires in accordance with ¶358.2a or ¶358.3 of *The Book of Discipline* or who is a Terminated Participant, age 55.
- 2.30 Early Retirement Date.** The first day of the month coinciding with or next following the date an Employee Retires:
- (a) in the case of a Clergy Employee, on or after:
 - (i) the age or service completion date specified in ¶358.2b of *The Book of Discipline*; or
 - (ii) age 55, in the case of a Clergy Employee who Retires in accordance with ¶358.2a (20 years of service) or ¶358.3 (involuntary retirement) of *The Book of Discipline*; or
 - (b) in the case of a Clergy person of a Disaffiliated Church or a Lay Employee who is employed by:
 - (i) a General Agency, on or after the date specified in the General Agency's policy on elective retirement for pension purposes (which must be consistent with ¶715.3 of *The Book of Discipline*); or
 - (ii) any Plan Sponsor other than a General Agency, in accordance with the Plan Sponsor's retirement policy.
- 2.31 Elder in Full Connection.** A member of the Order of Elders within the meaning of ¶332-¶336 of *The Book of Discipline* who is a member of a Conference and not a Provisional Member.

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- 2.32 Employee.** A person who is described as an employee of a church in §414(e)(3) or §7701(a)(20) of the Code, who is a Bishop of The United Methodist Church, who is a Clergy person serving The United Methodist Church or a Disaffiliated Church, or who is a common-law employee of a Salary-Paying Unit.
- 2.33 Employee Contributions.** The contributions made by an Employee pursuant to Section 4.05.
- 2.34 ERISA.** The Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulation, ruling, or other administrative guidance issued pursuant thereto by the Internal Revenue Service or the Department of Labor.
- 2.35 Five-Year No Record of Appointment.** With respect to a Probationary Member, Associate Member, Deacon in Full Connection, or Local Pastor, a 60-consecutive-month period during which the Probationary Member, Associate Member, Deacon in Full Connection, or Local Pastor (or some combination in the case of a Clergy person who changes classification) is not Under Episcopal Appointment.
- 2.36 FMLA.** The Family and Medical Leave Act of 1993, as amended from time to time.
- 2.37 Form.** Any means of recording and conveying an authenticated election or other authenticated information to the Plan Administrator, Claim Administrator, Salary-Paying Unit, or Plan Sponsor, including, but not limited to, the following:
- (a) A signed paper form;
 - (b) A form submitted by internet or extranet, that is authenticated in a manner acceptable to the Plan Administrator, Claim Administrator, Salary-Paying Unit, or Plan Sponsor to which the form is directed;
 - (c) An interactive voice response selection that is authenticated in a manner acceptable to the Plan Administrator, Claim Administrator, Salary-Paying Unit, or Plan Sponsor to which the selection is directed; and
 - (d) A recorded oral election or statement of information that is authenticated in a manner acceptable to the Plan Administrator, Claim Administrator, Salary-Paying Unit, or Plan Sponsor to which the election or statement of information is directed.
- 2.38 General Agency.** A general agency of The United Methodist Church as defined in ¶701 of *The Book of Discipline*.
- 2.39 General Conference.** The General Conference of The United Methodist Church, the highest legislative body in the denomination, as described in Section I of Chapter Four of Part VI of *The Book of Discipline*.
- 2.40 Health Savings Account (HSA).** A trust or custodial account that satisfies the requirements of Code §223.

- 2.41 High Deductible Health Plan (HDHP).** A Benefit Option under the Plan that complies with the requirements for a “high deductible health plan” as set forth in Code §223.
- 2.42 HIPAA.** The Health Insurance Portability and Accountability Act of 1996.
- 2.43 HIPAA Regulations.** The regulations promulgated pursuant to the authority granted under HIPAA by the Secretary of the Department of Health and Human Services.
- 2.44 HRA.** A Health Reimbursement Account, described in Article IX, which is health reimbursement arrangement as described in *IRS Notice 2002-45*. HRAs are employer-funded (i.e., Plan-funded and, if applicable, Plan Sponsor-funded) accounts that help Participants covered in an HRA-eligible Benefit Option as determined before the beginning of each Plan Year by the Plan Administrator and by the election of the Plan Sponsor, satisfy higher deductibles and other out-of-pocket expenses by reimbursing certain eligible medical expenses. HRAs also help Retired HRA Participants pay for out-of-pocket health care expenses in retirement. HRAs do not include any Participant contributions.
- 2.45 Insurer.** A third party that pays for benefits under the Plan through an insurance policy or agreement with the Plan Administrator, under which the third party has agreed to insure the Plan for the cost of such benefits and administer claims for such benefits in exchange for a premium paid by the Plan.
- 2.46 Jurisdictional Conference.** One of the organizational units of The United Methodist Church, as described in Section II of Chapter Four of Part VI of *The Book of Discipline*.
- 2.47 Lay Employee.** Any Employee who is not a Clergy Employee. In addition, any Employee who is a Clergyperson but who is not:
- (a) an Active Conference Member; or
 - (b) under Episcopal Appointment to a Plan Sponsor
- is a Lay Employee for the purposes of this Plan. This definition will not affect the fact that the Code treats certain Clergypersons (generally certain Deacons in Full Connection) as lay employees. Such Clergypersons and all Lay Employees may not be eligible for this Plan under Section 3.02(d) and §414(e) of the Code if they are employed by an entity that is not controlled by or associated with The United Methodist Church.
- 2.48 Leave of Absence.** An Employee’s period of absence from performing his or her duties for a Plan Sponsor:
- (a) in accordance with ¶352 of *The Book of Discipline* or any Plan Sponsor leave policy relating to sabbatical leaves;
 - (b) in accordance with ¶354 and ¶355 of *The Book of Discipline* or any Plan Sponsor leave policy relating to leaves of absence;

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- (c) in accordance with ¶356 of *The Book of Discipline* or any Plan Sponsor leave policy relating to maternity or paternity leaves;
- (d) because of a Medical Leave (under ¶357 of *The Book of Discipline*) or any Plan Sponsor leave policy relating to illness, injury, disability, medical or incapacity leaves (but not including any such leave for which salary continuance is offered);
- (e) that is covered by USERRA (or applicable prior law); or
- (f) to which the Employee is entitled under the FMLA or any comparable applicable state law;

provided, however, that the Employee Retires or returns to at least one hour of paid service for the Plan Sponsor or its Affiliate within the time specified when his or her leave is approved, including any later adjustments thereto (or, if applicable, within the period during which his or her re-employment rights are protected by law).

- 2.49 Local Pastor.** A person licensed in accordance with Section IV of Chapter Two of Part VI of *The Book of Discipline* (¶315-¶320).
- 2.50 Medical Leave**Error! Bookmark not defined.. (Formerly called Incapacity Leave) A Conference relationship specified in ¶357 of *The Book of Discipline* applicable to Clergypersons. A Clergyperson must be placed on Medical Leave by his or her Conference, and not by a Plan Sponsor that is not a Conference. In the case of Bishops, Medical Leave, called Incapacity Leave for Bishops, is granted in accordance with ¶410.4 of *The Book of Discipline*. Individuals appointed to Medical Leave are not necessarily considered Disabled for the purposes of the Plan.
- 2.51 Health Care FSA.** A Health Care FSA program, i.e., a health care flexible spending account arrangement, established by the Plan Administrator in accordance with Article VII.
- 2.52 Missionary Conference.** A special purpose conference of The United Methodist Church similar to an Annual Conference, as further described in Section VII of Chapter Four of Part VI of *The Book of Discipline*.
- 2.53 Normal Retirement Date.** The first day of the month coinciding with or next following the earlier of:
- (a) the Employee's 65th birthday; or
 - (b) the date on which the Participant who is:
 - (i) a Clergyperson attains 40 years of service under ¶358.2c of *The Book of Discipline*;
 - (ii) a Lay Employee of a General Agency satisfies the requirements for normal or full retirement under the General Agency's policy on retirement of Employees; or

- (iii) a Clergy person of a Disaffiliated Church or a Lay Employee of a Plan Sponsor other than a General Agency qualifies under any normal retirement policy the Plan Sponsor may have that applies to this Plan.

2.54 Notice. Any means of officially conveying Plan-related information to an Employee, a Participant, a Dependent, the Plan Administrator, Claim Administrator, a Salary-Paying Unit, a Plan Sponsor, or any other entity related to the Plan, including, but not limited to, the following:

- (a) A paper communication;
- (b) An internet or extranet communication;
- (c) An e-mail or other electronic communication;
- (d) An interactive voice response recorded statement; and
- (e) An oral communication that is recorded and, when reasonably required, otherwise verifiable as to the originator of the communication.

When a communication would reasonably be acceptable only if signed, notarized, or otherwise authenticated, it must be signed, notarized, or otherwise authenticated. An unrecorded oral communication will not qualify as a Notice unless the Plan Administrator has established a rule allowing such an oral communication to qualify as a Notice.

2.55 Other Group Health Plan. Coverage or insurance including a self-insured group health plan; an individual or group health insurance or HMO plan; Parts A and B of Medicare; Medicaid; a health plan for current and former members of the armed forces; a health plan provided through Indian Health Services; a state health benefit risk pool; The Federal Employees Health Program; a plan provided under the Peace Corps Act; a state, county, or municipal public health plan; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; coverage provided under state or federal health continuation mandates (e.g., COBRA); individual or group health insurance through an association; or an individual or group health conversion plan.

2.56 Participant. Any Employee who has become eligible to participate in the Plan in accordance with Section 3.01, who has enrolled in the Plan.

- (a) **Active Participant.** Any Participant who is not a Disabled Participant, Retired Participant, or Terminated Participant.
- (b) **Disabled Participant.** Any Participant who is Disabled.
- (c) **Retired Participant.** Any Participant who is described in Sections 3.03(a), (b)(vii), (d), (e)(ii), or (f), below, who has satisfied the requirements of Section 3.05(e).
- (d) **Terminated Participant.** A person described in Section 2.77.

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- 2.57 Pastoral Charge.** One or more Local Churches within the meaning of ¶205 of *The Book of Discipline*.
- 2.58 Period of Coverage.** 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 provided in Section 5.04;
 - (b) for Employees who terminate participation, it shall mean the portion of the Plan Year up to the date participation terminates; and
 - (c) for Participants electing salary reduction contributions under Section 10.02, the month for which the contribution is made.
- 2.59 PHSA.** The Public Health Service Act (Public Law 78-410) as amended by the PPACA.
- 2.60 Plan.** HealthFlex Plan, an employee welfare benefit and cafeteria plan of The United Methodist Church, as further described in Section 1.03, as amended.
- 2.61 Plan Administrator.** Wespath, or any successor.
- 2.62 Plan Sponsor.** An entity specified in Section 1.06 that has executed an Adoption Agreement with respect to those of its Employees who are:
- (a) permitted to be covered under Section 1.06(b); and
 - (b) specified by type or class of Employee in the Adoption Agreement.
- 2.63 Plan Sponsor Contributions.** The contributions made by a Salary-Paying Unit or a Plan Sponsor pursuant to Section 4.05.
- 2.64 Plan Year.** The 12-month period ending on December 31 of each calendar year.
- 2.65 PPACA.** The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) (including the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)), also known as the Health Care Reform Act, the Affordable Care Act, and the ACA, which substantially amended the Code, ERISA and the PHSA, and which affects the Plan through various insurance market and group health plan reforms.
- 2.66 Privacy Rule.** The Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (CFR) parts 160 and 164, subparts A and E.
- 2.67 Protected Health Information.** Protected Health Information or “PHI” shall have the same meaning as the term “protected health information” at 45 CFR §160.103, limited to the information created or received by Wespath and Plan.
- 2.68 Provisional Member.** A person elected to provisional membership in an Annual Conference within the meaning of ¶324 of *The Book of Discipline*.

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- 2.69 Recordkeeper.** Wespath or a third-party administrator or custodian appointed by Wespath pursuant to Section 7.08 or Section 8.11.
- 2.70 Required Contribution.** Required Contributions include, but are not limited to, amounts due under Section 4.05, premiums for coverage under the Plan, and any other amounts due as a condition of receiving coverage under the Plan.
- 2.71 Retire(d) or Retirement.** In the case of:
- (a) a Clergy person (other than a Clergy person of a Disaffiliated Church), either:
 - (i) being placed in the retired relation in accordance with ¶358 of *The Book of Discipline*; or
 - (ii) incurring, on or after his or her Early Retirement Date a Termination of Employment and either:
 - (A) a Termination of Conference Relationship; or
 - (B) a Five-Year No Record of Appointment;
 - (b) a Clergy person of a Disaffiliated Church or a Lay Employee, the earliest of:
 - (i) the date such individual incurs a Termination of Employment on or after his or her Early Retirement Date;
 - (ii) in the case of a Disabled individual, his or her Early Retirement Date or Normal Retirement Date; or
 - (iii) in the case of an individual on an approved Leave of Absence who does not return to work at the scheduled end of a Leave of Absence, the date the Leave was scheduled to end if such date is on or after his or her Early Retirement Date; or
 - (c) a Terminated Participant, his or her Early Retirement Date or Normal Retirement Date, if his or her Plan Sponsor allows the option to become a Retired Participant to be tolled in certain circumstances during the period of time between the Termination of Employment and the Early Retirement Date or Normal Retirement Date.
- 2.72 Retired Employee.** A Clergy Employee or Lay Employee who has Retired.
- 2.73 Retirement Date.** The date on which a Participant satisfies the requirements of Section 2.56(c).
- 2.74 Salary-Paying Unit.** One of the following units that is controlled by or associated with The United Methodist Church and located in the United States of America:
- (a) the General Conference;
 - (b) a General Agency of The United Methodist Church;

- (c) a Jurisdictional Conference;
- (d) a Conference located in a Jurisdictional Conference;
- (e) a Conference board, agency, or commission located in a Jurisdictional Conference;
- (f) a local church located in a Conference;
- (g) any other organization located in a Jurisdictional Conference which is eligible to participate in a Church Plan in accordance with the provisions of ERISA and the Code;
or
- (h) a Disaffiliated Church.

2.75 Security Rule. The standards for the security of electronic protected health information at 45 CFR 164, Subpart C.

2.76 Spouse. The husband or wife or surviving husband or wife of a Participant who is legally married to such Participant or was so legally married on the date of the Participant's death, under the laws of the jurisdiction where the Participant resides or resided. Notwithstanding the foregoing, the term "Spouse" will not include common law spouses, even in states that recognize common law marriage.

2.77 Terminated Participant. A person who has been a Participant under the Plan as sponsored by a Plan Sponsor, but who:

- (a) in the case of a Clergy person of a Disaffiliated Church or a Lay Employee, has incurred a Termination of Employment with such Plan Sponsor or elects to terminate participation during an Annual Election and Enrollment Period or on account of a Change in Status;
- (b) in the case of a Clergy Employee other than a Clergy person of a Disaffiliated Church, has incurred a Termination of Conference Relationship, or elects to terminate participation during an Annual Election and Enrollment Period or on account of a Change in Status;
- (c) is a Dependent of an Employee and: (i) ceases to be a Dependent as defined in Section 2.25, or (ii) ceases to be covered under the Plan by the election of the Participant during an Annual Election and Enrollment Period or on account of a Change in Status;
- (d) is a Retired Participant who has elected to terminate participation in the Plan at any time;
- (e) is a Disabled Participant and ceases to be Disabled as defined in Section 2.27;
- (f) is excluded from participation pursuant to Section 3.06(f) or by operation of any other Plan rule or provision;

- (g) is enrolled in the Plan at the time his or her Plan Sponsor terminates its sponsorship of the Plan;
- (h) is enrolled in the Plan at the time the Plan is terminated by Wespath, or
- (i) becomes ineligible for the Plan under his or her Plan Sponsor's policy for individuals covered by an approved Medicare Secondary Payer Small Employer Exception.

Notwithstanding the foregoing, a Terminated Participant may elect to continue coverage under the Plan pursuant to Section 3.06(e) only as long as permitted by the Plan and the applicable Adoption Agreement.

2.78 Termination of Conference Relationship. A Participant ceasing to be a member of any Conference, including by reason of:

- (a) being honorably located within the meaning of ¶359 of *The Book of Discipline*;
- (b) his or her withdrawal within the meaning of ¶361 of *The Book of Discipline*;
- (c) the surrender of his or her ministerial credentials within the meaning of ¶361.2 and ¶2720.2 of *The Book of Discipline*; or
- (d) the surrender of his or her Local Pastor's license within the meaning of ¶320.1 of *The Book of Discipline*.

2.79 Termination of Employment.

- (a) **General Rule.** A non-conference responsible Clergy Employee or a Lay Employee will be deemed to have incurred a Termination of Employment with a Plan Sponsor as a result of his or her:
 - (i) resignation or dismissal for any reason (whether or not it qualifies as a Retirement);
 - (ii) the end of a Clergy Employee's Appointment to such Plan Sponsor that results in the Employee's severance from employment with such Plan Sponsor as both a Clergy Employee and as a Lay Employee;
 - (iii) death;
 - (iv) failure to return to work promptly upon the request of such Plan Sponsor at the end of a layoff;
 - (v) failure to return to work within the period required under USERRA or any other law pertaining to veterans' re-employment rights after having started an authorized Leave of Absence for military duty with the armed forces of the United States as defined under such law;
 - (vi) failure to Retire or return to work at the end of a Leave of Absence; or

(vii) transfer from such Plan Sponsor to another Plan Sponsor;

provided that such Retirement, resignation, dismissal, end of Appointment, death, failure to return, failure to Retire, or transfer involves a severance from employment with such Plan Sponsor.

(b) ***Failure to Return after Layoff or Leave.*** If a Termination of Employment occurs within the meaning of Sections 2.79(a)(iv)-(vi), such termination will be deemed to have occurred on the first day of the layoff or Leave of Absence. An Employee who timely returns to work with such Plan Sponsor at the end of the layoff or Leave of Absence will not have incurred a Termination of Employment with such Plan Sponsor by reason of such layoff or Leave of Absence.

2.80 Treasury Regulation. Any applicable regulation issued by the Department of the Treasury or Internal Revenue Service that is codified at Title 26 of the Code of Federal Regulations (which may include, as determined by the Plan Administrator, proposed and temporary regulations). Where a reference is made to temporary or proposed regulations, such reference will include any permanent regulations, modified proposed regulations, or temporary regulations issued in lieu thereof.

2.81 Trust. The trust or trusts, including the Employee Health Benefit Trust of The United Methodist Church, established to fund certain benefits provided under the Plan, as provided in Section 1.05(a). The term “Trust” will also include, as applicable, any insurance contract purchased to fund benefits under the Plan.

2.82 Trust Agreement. The agreement or agreements between the Plan Administrator and the Trustee pursuant to which the Trust is established.

2.83 Trustee. Wespeth, or any successor.

2.84 Under Episcopal Appointment. The condition of a Clergy person who has been appointed by a Bishop to a ministry pursuant to ¶425 through ¶430, Section VIII of Chapter Three of *The Book of Discipline*.

2.85 USERRA. The Uniformed Services Employment and Re-employment Rights Act of 1994.

2.86 Wespeth. An administrative general agency of the United Methodist Church.

Article III – Eligibility

3.01 General Rule. An Employee shall be eligible to participate in this Plan if the Employee meets the requirements of Sections 3.02, 3.03, or 3.06 below and the enrollment requirements of Section 3.05, and if he or she is not excluded from participation in accordance with the provisions of Sections 3.04 or 3.06 below.

3.02 Basic Participation. An Employee who is one of the following shall be eligible to participate in this Plan:

- (a) an active Bishop of The United Methodist Church;
- (b) a Clergy Employee of a Conference, including full, probationary, and associate, who is Appointed:
 - (i) to full-time service in a Local Church in accordance with ¶337.1 or ¶346.1 of *The Book of Discipline*; or
 - (ii) to an Appointment extending the ministry of the local United Methodist church within the connectional structure to a unit of the Conference in accordance with ¶344.1 of *The Book of Discipline*;
- (c) a full-time Local Pastor determined in accordance with ¶318.1 of *The Book of Discipline* who is Under Episcopal Appointment to a Pastoral Charge that is located in a Conference;
- (d) a Lay Employee of a General Agency who is normally scheduled to work 30 or more hours per week, excluding, however, a person who is employed by a General Agency as a missionary of The United Methodist Church;
- (e) a Clergy Employee of a General Agency;
- (f) a Clergy Employee of a Disaffiliated Church; or
- (g) a Lay Employee of a Plan Sponsor other than a Conference or General Agency who is normally scheduled to work 30 hours or more per week.

3.03 Additional Participation. An Employee in one of the following categories shall be eligible to participate in this Plan if his or her Plan Sponsor elects, pursuant to an Adoption Agreement, to enroll the category of Employee, set forth below, in which he or she falls.

- (a) a Bishop who has Retired in accordance with ¶408.1, ¶408.2, or ¶408.3 of *The Book of Discipline*;
- (b) a Clergy Employee of a Conference who:
 - (i) is Appointed to less than full-time service in accordance with ¶338.2 of *The Book of Discipline*, but who is Appointed to at least half-time time service;

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- (ii) is Appointed beyond the local United Methodist Church within the connectional structure to an entity other than a unit of a Conference or other than a General Agency in accordance with ¶344.1a of *The Book of Discipline*, including full-time Local Pastors so Appointed in accordance with ¶317 of *The Book of Discipline*;
 - (iii) is Appointed beyond the local United Methodist Church to an extension ministry endorsed by Wespeth of Higher Education and Ministry in accordance with ¶344.1b of *The Book of Discipline*;
 - (iv) is Appointed beyond the local United Methodist Church outside the connectional structure in accordance with ¶344.1d of *The Book of Discipline*;
 - (v) is granted a Leave of Absence;
 - (vi) is Appointed to attend school in accordance with ¶416.6 of *The Book of Discipline*;
or
 - (vii) has Retired in accordance with ¶357.1, ¶357.2a , ¶357.2b, ¶357.2c, or ¶357.3 of *The Book of Discipline*.
- (c) a Local Pastor of The United Methodist Church who is Under Episcopal Appointment and who is:
- (i) a “part-time local pastor” as that term is defined in ¶318.2 of *The Book of Discipline*, who is Appointed to at least a three-quarter time appointment; or
 - (ii) a “student local pastor” as that term is defined in ¶318.3 of *The Book of Discipline*.
- (d) a full-time Local Pastor who was eligible to participate in the Plan and who has been recognized as a Retired Local Pastor in accordance with ¶320.5 of *The Book of Discipline*;
- (e) a Lay Employee of a Conference or Salary-Paying Unit within a Conference who:
- (i) is normally scheduled to work 30 hours or more per week; or
 - (ii) has Retired at Early Retirement Age or Normal Retirement Age in accordance with the retirement policy of the Salary-Paying Unit from which he or she has Retired.
- (f) a Lay Employee of a General Agency or other Plan Sponsor who has Retired in accordance with the retirement policy of the General Agency or Plan Sponsor from which he or she has Retired.

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3.04 Exclusions.

- (a) A Clergy person shall be excluded from participation in the Plan when:
 - (i) he or she is granted “honorably discharged” as that term is defined in ¶359.1 of *The Book of Discipline*; or
 - (ii) he or she is granted a status as defined in ¶361 of *The Book of Discipline*.
- (b) A Lay Employee shall be excluded from participation in the Plan when he or she:
 - (i) normally is scheduled by the Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week;
 - (ii) normally is scheduled by the Plan Sponsor or Salary-Paying Unit to work more than 30 hours per week during a period of time that is fewer than six continuous months, even if such Lay Employee is normally scheduled by the Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week beyond six months; or
 - (iii) is a temporary or seasonal Lay Employee normally scheduled by his or her Plan Sponsor or Salary-Paying Unit to work fewer than six continuous months during a Plan Year.
- (c) If so provided by the applicable Plan Sponsor’s policy, a Participant or Dependent who attains age 65 and is covered by an approved Medicare Secondary Payer Small Employer Exception shall no longer be eligible for the Plan.
- (d) A new Dependent acquired by a Retired Employee after the Retirement Date shall not be eligible to join the Plan.
- (e) An Employee who is reasonably expected to reside outside of the United States for more than six continuous months at a time shall not be eligible for the Plan.

3.05 Enrollment Requirements.

- (a) Wespath may establish enrollment and coverage requirements that a Plan Sponsor must satisfy in order to participate in the Plan, and Wespath may amend such requirements from time to time.
- (b) The Plan Sponsor must make the Plan available to all of its eligible Employees in the Basic Participation Group in Section 3.02, if any, and to all of its eligible Employees in the categories that it selected for the Additional Participation Group in Section 3.03 on a nondiscriminatory basis in accordance with the applicable nondiscrimination rules of the Code and the PPACA, but may exclude Lay Employees who are normally scheduled to work fewer than 30 hours per week and other Employees defined in Section 3.04(b).
- (c) In order to participate in this Plan, an Employee must enroll in the Plan within 31 days of becoming eligible to participate in the Plan or during an Annual Election and Enrollment

Period. The Employee's Plan Sponsor has the duty to timely submit enrollment materials and Forms from Employees to the Plan Administrator.

- (d) An Employee shall be denied enrollment in the Plan if he or she does not meet the conditions of Section 3.05(c) in accordance with rules and regulations established by the Plan Administrator.
- (e) ***Retired Participants.*** An eligible Employee described in Sections 3.03(b)(vii), (d), (e)(ii), or (f) shall be eligible to participate in the Plan, subject to the terms of the Adoption Agreement of his or her Plan Sponsor, and the retirement eligibility rules of his or her Plan Sponsor, as a Retired Participant. In addition, a Spouse who is married to an Employee in one of the categories described in this Section is eligible to become a Retired Participant as described in this Section subject to the Adoption Agreement and eligibility rules of the Plan Sponsor, although he or she will immediately lose such eligibility if the Employee or Retired Participant to whom he or she is married loses his or her eligibility unless such loss of eligibility is on account of the Employee's death.
 - (i) *Years of Coverage and Plan Sponsor Requirements.* Notwithstanding anything else in the Plan to the contrary, to become a Retired Participant in the Plan, a Retired Employee must satisfy the eligibility rules for Retired Participant coverage established and maintained by his or her Plan Sponsor. Any such additional Plan Sponsor requirements must be established and maintained pursuant to a written policy that is distributed to Employees and a copy of which is provided to the Plan Administrator upon request. Plan Sponsors have a duty to submit copies of such policies in a timely manner to the Plan Administrator, upon request.
 - (ii) *Cost sharing by Plan Sponsors.* Notwithstanding the foregoing, Plan Sponsors may establish policies for sharing or subsidizing the cost of coverage (i.e., the Required Contributions) for Retired Participants under the Plan. Plan Sponsors must memorialize their cost-sharing policy in a written document that shall be: (1) submitted to Wespath upon request, (2) publicized through the Plan Sponsor's usual methods of communications, and (3) shared with Participants approaching Retirement.

3.06 Special Rules.

- (a) A Plan Sponsor, with the written agreement of Wespath, may enroll other individuals in a category not specifically described above, provided that such category is one that may participate in a cafeteria plan (under §125 of the Code) and a Church Plan. Such individuals will be subject to all other terms of the Plan including the risk pool rules established under Section 1.08.
- (b) A person who is Disabled can participate in this Plan if he or she was a Participant at the time he or she became disabled if elected by the Plan Sponsor in Exhibit A to the Adoption Agreement. The Salary-Paying Unit or Plan Sponsor shall remain responsible for remitting Required Contributions for the coverage of the Disabled Participant. However, the Salary-Paying Unit or Plan Sponsor may separately arrange with the Disabled

Participant the manner in which those costs are shared between them, which may be different than other categories of Participants. In addition, a Disabled Participant may arrange with Wespath to pay the portion of Required Contributions for which he or she is responsible by deduction from his or her disability distributions from a disability plan administered by Wespath.

In addition, a person who is a Member of a Conference that is a Plan Sponsor of this Plan, who is Appointed to serve in another Conference that is not a Plan Sponsor of this Plan under ¶346.1 of *The Book of Discipline*, can participate in this Plan as a Disabled Participant if he or she must return to the Conference in which he or she is a Member for incapacity leave and disability plan benefits in accordance with *The Book of Discipline*, so long as (1) the Conference that is a Plan Sponsor remits the Required Contributions for coverage of the Disabled Participant, and (2) the Disabled Participant maintained continuous creditable coverage under the Other Group Health Plan of the Conference to which he or she was Appointed.

- (c) **Family Leave.** A Participant who is placed on maternity or paternity leave pursuant to ¶356 of *The Book of Discipline* shall continue his or her participation in the Plan on the same basis as immediately prior to being granted such leave for a period not less than 12 weeks.
- (d) The Spouse and Dependents of a Participant shall be eligible for coverage under this Plan pursuant to:
 - (i) the rules established by the Plan Administrator;
 - (ii) the applicable Benefit Options; and
 - (iii) the choices elected by the Plan Sponsor on its Adoption Agreement.

A Plan Sponsor may elect, through its Adoption Agreement to offer coverage for the same-sex partner who has entered a civil union or domestic partnership, which, under the law of the state in which the Employee resides, provides the same substantive and procedural rights, privileges, and immunities as marriage. Such coverage shall be subject to the limitations of federal law, i.e., with respect to the Code, and the conditions described in Judicial Council Decision Nos. 1030, 1075 and 1264, and *The Book of Discipline*.

In accordance with the PPACA, for any Benefit Option under the Plan that provides coverage to Dependent children of Participants, such Benefit Option will cover Participants' children who are under age 26. For the purposes of this Section 3.06(d), a "child" includes a Participant's or a Participant's Spouse's child, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom a Participant or his or her Spouse is the legal guardian.

- (e) **Continuation Coverage.** The Plan Administrator shall establish appropriate rules and regulations with respect to continuation coverage taking into consideration applicable federal and state laws. Because the Plan is a Church Plan, it is exempt, pursuant to §4980B

of the Code, from the requirements of COBRA. This Plan is also exempt from the requirements of Illinois state law under ILCS 215/5 and 215/125. However, the Plan will generally offer 18 months of continuation coverage for medical, mental health, and prescription drug coverage in accordance with the rules established by the Plan Administrator. Even if the Plan, in its discretion, offers continuation coverage that has attributes of continuation coverage under state law or COBRA, the Plan does not become subject to COBRA or state law. In addition, Wespeth, in its discretion, may extend Continuation Coverage offered to Terminated Employees beyond the term of the generally established rules for Continuation Coverage for certain reasons such as severance arrangements, settlement of litigation or satisfaction of other claims.

- (f) A Plan Sponsor or an Employee may be excluded from continued participation in the Plan for failure to make Required Contributions on a timely basis. An Employee may also be excluded if the Salary-Paying Unit that is responsible for making Required Contributions on his or her behalf fails to make such Required Contributions. The Plan Administrator may adopt in writing a Premium Collection Policy for the Plan that provides for policies and procedures to be used in circumstances as the Plan Administrator deems appropriate in its sole discretion. The Premium Collection Policy is hereby incorporated by reference.
- (g) ***Qualified Medical Child Support Orders.*** The Plan Administrator may determine that the Plan may provide benefits in accordance with the applicable requirements of any qualified medical child support order (a “QMCSO”), as defined in §609 of ERISA or other medical support order, including a National Medical Support Notice issued pursuant to the Child Support Performance and Incentive Act of 1998, that the Plan Administrator reasonably determines apply to the Plan, relating to the child of a Participant. The Plan Administrator or its agent shall pay benefits payable to a child covered by a QMCSO or other applicable support order directly to the child or to such child’s parent or legal guardian and will bill the applicable Plan Sponsor, as the Plan Administrator determines is appropriate.

Article IV – Participant Accounts and Contributions

- 4.01 Provisions for Participant Accounts.** The Plan Administrator shall maintain a Participant Account or Accounts for each Participant who participates in the Health Care FSA, the Dependent Care FSA, or the Health Reimbursement Account. If a Participant elects to contribute to a Health Care FSA, the Plan Administrator shall establish a Health Care FSA on behalf of that Participant. Likewise, if the Participant elects to contribute to a Dependent Care FSA, the Plan Administrator shall establish a Dependent Care FSA on behalf of that Participant. If the Plan Sponsor elects to contribute to a Health Reimbursement Account or the Participant selects a plan that includes a Health Reimbursement Account, the Plan Administrator shall establish a Health Reimbursement Account on behalf of that Participant. Collectively, the Health Care FSA, the Dependent Care FSA, and the Health Reimbursement Account make up the Participant Accounts, and each separately is a Participant Account.
- 4.02 Crediting Participant Accounts.** The Recordkeeper shall credit amounts to the Participant Accounts in accordance with Section 4.05 below.
- 4.03 Debiting Participant Accounts.** The Recordkeeper shall debit each Participant Account in accordance with the rules of the Benefit Option in which the Participant is enrolled and pursuant to the direction of the Claims Administrator and Plan Administrator.
- 4.04 Nature of Participant Accounts.** No money shall actually be allocated to any Participant Account; any such Account shall be of a memorandum nature, maintained by the Recordkeeper for the Plan and Plan Administrator's accounting purposes. No interest will be credited to or paid on amounts credited to the Participant Accounts.
- 4.05 Source of Credits to Participants Accounts.** Credits applied to the Participant Accounts shall be derived from the following sources.
- (a) ***Active Employee Contributions.*** During the applicable Election Period or Annual Election Period determined under Article V, an Active Employee may enter into a salary reduction agreement with his or her Salary-Paying Unit. No money or other contributions shall be paid by any Active Employee to his or her Participant Accounts, other than as provided by this Article IV.
 - (b) ***Plan Sponsor Contributions.*** For any Period of Coverage, the Salary-paying Unit and Plan Sponsor shall make contributions on behalf of its Participants in an amount determined by the Plan Sponsor or Wespath, as applicable. Any such Plan Sponsor Contributions shall be made only on a nondiscriminatory basis within each category (i.e., Active Employee, basic or optional participation, and Lay Employee or Clergy Employee).
- 4.06 Exchange Program.** Plan Sponsors will offer eligible individuals a choice of designated Benefit Options and will agree to provide a fixed Plan Sponsor Contribution, as determined by Plan Sponsor in consultation with Wespath each Plan Year. The fixed Plan Sponsor Contribution will be applied as a credit toward the cost of the Benefit Option(s) selected by the eligible individual, with any shortfall paid to the Plan Sponsor by the eligible individual or by the Salary-Paying Unit, and any excess applied to the eligible individual's HSA or HRA.

Article V – Elections

- 5.01 In General.** The Plan Administrator shall enact uniform and nondiscriminatory rules for making elections. Participants shall make their elections in accordance with these rules. The Plan Administrator shall provide, by electronic and written means, materials that contain information regarding the manner in which Participants may make elections prior to each Period of Coverage. Participants shall make such elections in the manner prescribed by the Plan Administrator.
- 5.02 Contributions and Benefits.** Participants may designate the amount of contributions, if any, to be allocated to the Health Care FSA, the Dependent Care FSA, or the Health Savings Account for an elected Period of Coverage. Contributions allocated to a particular Benefit Option shall not be used for any other Benefit Option.
- 5.03 Period of Coverage.** Except as provided in Sections 5.04 and 5.07, any Participant electing contributions and benefits must make an election for an entire Period of Coverage.
- 5.04 Fractional Periods.** A Participant who becomes eligible to participate in the middle of a Period of Coverage may elect to participate for a period lasting from the date on which he or she becomes eligible until the end of the then-current Period of Coverage. In such cases, the interval commencing the day after the elections are made and ending at the end of the then-current Period of Coverage shall be deemed to be the Period of Coverage. Such Participants must elect to participate no later than 31 days after becoming eligible to do so or within such other time limit as the Plan Administrator may prescribe.
- 5.05 Timing of Elections.** Generally, elections of contributions and Benefit Options for a Period of Coverage shall be made prior to the Period of Coverage.
- 5.06 No Election.** If a Participant fails to make an election relating to any coverage under the Plan on or before the specified due date for making such election and such Participant did not participate in the Plan the prior Plan Year, the Participant will not be able to participate in the Plan for the Plan Year. Except as otherwise specified by the Plan Administrator and communicated to Participants for a Plan Year, if a Participant elects coverage under a Benefit Option for a Plan Year but fails to make an election relating to any coverage under such Benefit Option for the immediately following Plan Year, the Participant shall be deemed to have elected the coverage under such Benefit Option that he or she elected for the prior Plan Year, provided that such coverage or comparable coverage, continues to be available under the Plan. A Participant shall be deemed not to have elected any amounts to be credited to a Health Care FSA, Dependent Care FSA, or Health Savings Account for any subsequent Plan Year unless such Participant makes a new election for such Plan Year.

5.07 Changes of Elections or Commencement of Participation during a Plan Year.

- (a) ***Change of Election.*** Elections with respect to coverage under the Plan shall be irrevocable by the Participant during the Period of Coverage; provided, however, that a Participant may revoke an election for the remainder of the Period of Coverage and file a new election, or an Employee who has otherwise satisfied the eligibility requirements set forth in Article III but has not heretofore elected to become a Participant in the Plan may elect to commence participation, only if: (1) both the revocation and the new election, or (2) the election to commence participation, as the case may be, is on account of and consistent with a Change in Status, as determined under this Section 5.07, or the election is otherwise allowed under this Section 5.07. A Participant is permitted to make Election changes during a Period of Coverage subject to the terms of Section 5.04 and only as provided in this Section 5.07. The determination of whether a revocation and new election or an election to commence participation is consistent with a Change in Status shall be determined by the Plan Administrator.

Any revocation of an election, new election, or change in an election shall be made within 30 days after the occurrence of an event described below and in the manner prescribed by the Plan Administrator for such purposes and shall be effective as of the first day of the first month after the receipt of such election by the Plan Administrator, or such earlier time as required by law.

This Section 5.07 is intended to permit a change in election, new election, or revocation of an election only in accordance with §125 of the Code and regulations and guidance thereunder and shall be interpreted in accordance with such intent. Accordingly, the Plan Administrator shall have the power to prescribe rules limiting an individual's right to make or revoke an election hereunder to the extent the Plan Administrator deems advisable in order to comply with §125 of the Code.

- (b) ***Change in Status.*** A "Change in Status" shall include the following events:
- (i) Change in the Employee's legal marital status;
 - (ii) Change in the number of the Employee's Dependents;
 - (iii) Termination or commencement of employment by the Employee, not including an appointment change, or by the Spouse or a Dependent of the Employee;
 - (iv) Strike or lockout affecting the employment status of the Employee or the Spouse or a dependent of the Employee;
 - (v) Change in the employment status of the Employee or the Spouse or a Dependent of the Employee that affects such person's eligibility under the Plan or an Other Group Health Plan;
 - (vi) Event that causes a Dependent of the Employee to satisfy or cease to satisfy the requirements for coverage due to attainment of a limiting age, loss of student status or any similar circumstances as provided in this Plan;

- (vii) Change in the place of residence or work of the Employee or the Spouse or Dependent of the Employee that affects such person's eligibility under the Plan or an Other Group Health Plan;
 - (viii) Commencement of a special enrollment period under HIPAA, as set forth in §9801(f) of the Code;
 - (ix) Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order as defined in §609 of ERISA) that requires accident or health coverage for a child of the Employee (including a foster child who is a Dependent) or that requires the Employee's Spouse, former Spouse or other individual to provide coverage for a child of the Employee and such coverage is in fact provided by such individual;
 - (x) Employee or the Spouse or a Dependent of the Employee, who is enrolled in a Group Benefit Plan that is an accident or health plan, becomes entitled to or loses coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under §1928 of the Social Security Act, the program for the distribution of pediatric vaccines;
 - (xi) A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for health plan coverage under the Plan, provided that the Participant certifies that he or she and any Dependents whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of coverage under the Plan; and
 - (xii) Such other events that the Plan Administrator determines will permit a change or revocation of an election or commencement of participation, during a Period of Coverage pursuant to Treasury Regulations or guidance issued under the Code.
- (c) ***Certain Changes in Coverage.***
- (i) If the cost of providing benefits under a Benefit Option is changed during a Plan Year and a Plan Sponsor elects not to pay some or all of the increase in such cost, or elects to apply any decrease to reduce a Participant's share of the cost under such Benefit Option, as the case may be, then the amount by which a Participant's compensation is reduced pursuant to a salary-reduction agreement shall be automatically adjusted consistent with the change in the cost to the Participant, as determined by the Plan Administrator.
 - (ii) A Participant shall be permitted to make a prospective election change with respect to his or her election (or decision not to make an election) for a Benefit Option for the remainder of the Plan Year if such change is on account of and corresponds with a change made under another employer-sponsored cafeteria

plan or qualified benefits plan (as defined in applicable regulations), including the plan of the Participant's Plan Sponsor or of another employer provided that (i) the period of coverage under such other plan is different from the Plan Year, or (ii) the change made under such other plan is pursuant to applicable regulations under §125 of the Code.

- (iii) During a Plan Year, an Eligible Person, or the Spouse or Dependent of an Eligible Person, who is not enrolled in the Plan shall be permitted to elect coverage under the Plan in a Benefit Option in accordance with the special enrollment rights under HIPAA, as provided in §9801(f) of the Code.
- (d) **Significant Cost Changes.** If the Plan Administrator determines that the cost charged to a Participant (i.e., the Required Contribution for coverage) significantly increases during a Period of Coverage, the Participant may make a corresponding change in election under the Plan for the balance of the Period of Coverage, which will include (but not be limited to) the following:
 - (i) Significant Cost Increase. For a significant cost increase, Participants electing such coverage for the Period of Coverage may revoke their election and either elect a similar coverage for the balance of the Period of Coverage or drop such coverage if there is no similar coverage; or
 - (ii) Significant Cost Decrease. For a significant decrease, Participants may elect to commence participation in the Benefit Option with the significant cost decrease and may make corresponding election changes regarding similar coverage for the balance of the Period of Coverage.
- (e) **Coverage Changes.** In the case of a Benefit Option, if the Participant or his or her Spouse or Dependent experiences a significant curtailment in coverage, in the reasonable judgment of the Plan Administrator during the Period of Coverage, the Participant may make a corresponding change in election under the Plan for the balance of the Period of Coverage as follows:
 - (i) Significant Curtailment without Loss of Coverage. For a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Period of Coverage may revoke his or her election and elect a similar coverage for the balance of the Period of Coverage; or
 - (ii) Significant Curtailment with Loss of Coverage. For a significant curtailment that is (or is deemed by the Plan Administrator to be) a loss of coverage, the Participant electing such coverage for the Period of Coverage may revoke his or her election and either elect a similar coverage for the balance of the Period of Coverage or drop such coverage if there is no similar coverage available.
- (f) If during the Period of Coverage, a new Benefit Option becomes available or an existing Benefit Option is significantly improved, Participants may elect the new or significantly improved Benefit Option, and may make corresponding election changes regarding similar coverage, for the balance of the Period of Coverage.

- (g) In the event that a Participant's Spouse or Dependent makes an election change under a plan maintained by his or her employer, the Plan Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Period of Coverage that is on account of and corresponds with the election change made by the Participant's Spouse or Dependent, if:
 - (i) §125 Election Change. The election change made by the Participant's Spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code §125; or
 - (ii) Change in Period of Coverage. The period of coverage under the plan maintained by the employer of the Participant's Spouse or Dependent does not correspond with the Period of Coverage of this Plan.
- (h) The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will determine, in accordance with prevailing Internal Revenue Service guidance, whether the facts and circumstances of any of the events in this Section 5.07 have occurred.
- (i) Any application for a revocation and new election under this Section 5.07 must be made within the time specified by the Plan Administrator following the date of the actual event and shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.
- (j) **Consistency Rule.** A Participant's requested revocation and new election under Section 5.07 will be consistent with a Change in Status if the election change is on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan or under a plan maintained by the employer of the Participant's Spouse or Dependent. A Change in Status that affects the eligibility under an employer's plan shall include a Change in Status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the Plan.
- (k) **Automatic Termination of Election.** Any election made under this Plan (including an election made through inaction under Section 5.06) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a Benefit Option or other employee benefit plan may continue if and to the extent provided by such Benefit Option or plan. In the event such a former Participant again becomes a Participant before the end of the same Plan Year, the elections previously in effect for the Participant under the Plan shall be automatically reinstated for the balance of the Plan Year, if the former Participant has become a Participant again within 90 days of the termination of participation, except as otherwise elected by the Participant in accordance with Section 5.07.
- (l) **Maximum Elective Contributions.** The maximum amount of elective Contribution under the Plan for any Participant shall be the maximum limits under Code §125 or such lower limit as the Plan Administrator may establish.
- (m) **Cessation of Required Contributions.** Nothing in this Plan shall prevent the cessation

of coverage or benefits under any Benefit Option, in accordance with the terms of such Benefit Option, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits (i.e., his or her portion of the Required Contribution), through Compensation reduction or otherwise.

- (n) ***Elections via Other Media.*** The Plan Administrator may, in its discretion, use any telephonic, electronic, or other alternative media form that it deems necessary or appropriate for the election of benefits under the Plan.
- (o) ***Dependent Care FSA Program Coverage Changes.*** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a Dependent Care Service Provider (as defined in Section 8.02). For example:
 - (i) 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
 - (ii) if the Participant terminates a Dependent Care Service Provider because a relative, including the Spouse, becomes available to take care of the child at no charge, the Participant may cancel coverage.
- (p) ***FMLA.*** 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 Plan Sponsor will continue to maintain the Participant's hospitalization, accident, prescription drug and other medical benefits coverage and, if applicable, Health Care FSA or Health Savings Account coverage on the same terms and conditions as if the Participant were still an Active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Plan Sponsor will continue to pay its share of the Required Contribution.

A Participant may elect to continue his or her coverage under the Group Health Plan, Health Care FSA, Dependent Care FSA, and Health Savings Account Program components of this Plan during the FMLA leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant shall pay his or her share of the Required Contributions in one of the following ways:

- (i) with after-tax dollars, by sending monthly payments to the Plan Sponsor;
- (ii) with pre-tax dollars, by pre-paying all or a portion of Required Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation. To pre-pay the Required Contributions, the Participant must make a special election to that effect prior to the date that such compensation normally be made available; or
- (iii) under another arrangement agreed upon between the Participant and the Plan Sponsor or Salary-Paying Unit (e.g., the Plan Sponsor or Salary-Paying Unit may fund coverage during the leave and withhold "catch-up" amounts upon the

Participant's return).

If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such FMLA leave on the same basis the Participant was participating in the Plan prior to the FMLA leave, or as otherwise required by the FMLA.

If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits such as the Dependent Care FSA will be determined by the Plan Sponsor's or Salary-Paying Unit's policy for providing such benefits when the Participant is on non-FMLA leave.

- (q) Notwithstanding anything in the Plan to the contrary, the irrevocability and election change rules described in this Article IV shall not apply to an HSA. Election changes with respect to an HSA may be made by a Participant at any time on a prospective basis in accordance with the rules established by the Plan Administrator, subject to any limitations under applicable law.
- (r) ***Temporary 2020 – 2022 Relief.*** The Coronavirus Aid, Relief and Economic Security Act of 2020, the Consolidated Appropriations Act 2021, and related guidance from the Internal Revenue Service provided temporary relief that allows Participants to change an election during a Period of Coverage. Notwithstanding anything herein to the contrary, effective August 27, 2020, and until December 31, 2021, a Participant may make the following election changes during a Period of Coverage:
 - (i) Elect new or different, or terminate previously elected, health coverage on account of and corresponding with a Spouse's change in employment status related to COVID-19 even when that change is not considered a Change in Status,
 - (ii) Change the amount of contributions the Participant previously elected to allocate to the Health Care FSA or the Dependent Care FSA, which may include starting new contributions, increasing or decreasing contributions, or ceasing contributions.

Such changes to contribution elections will be effective prospectively.

Article VI – Benefits

6.01 Benefits Available. A Plan Sponsor may make available to Participants the following Benefit Options:

- (a) **Health Care FSA** (for Active Participants who are Employees only). This Benefit Option is defined in Article VII herein.
- (b) **Dependent Care FSA** (for Active Participants who are Employees only). This Benefit Option is defined in Article VIII herein.
- (c) **Health Savings Account Program.** This Benefit Option is defined in Article X herein.
- (d) **Premium Conversion Program.** Payment shall be made to the Plan or the appropriate insurer of amounts equal to the premiums, Required Contributions or their equivalent otherwise payable by (or on behalf of) the Participant during the Period of Coverage, for coverage of the Participant, or the Participant's Spouse or Dependents, under the programs maintained by Wespath pursuant to this Plan, as set forth in Appendix A. Wespath may offer from time-to-time other programs through a cafeteria plan, pursuant to §125 of the Code. Subject to Section 6.02 below, each Participant shall have the option to select from among these Benefit Options subject to the terms of the Adoption Agreement of his or her Plan Sponsor. In the event of premium or Required Contribution changes that become effective during a Period of Coverage, a Participant's existing election as to a salary reduction shall automatically be adjusted to reflect the increases or decreases, as provided in Section 5.07(c)(i). Additionally, each Participant, in accordance with the Benefit Options offered by his or her Plan Sponsor under the terms of its Adoption Agreement, shall have the right to specify in his or her salary reduction agreement the amounts to be credited to his or her Health Care FSA, Dependent Care FSA, and/or Health Savings Account.
- (e) **Other Benefits.** In the course of providing medical and other health care benefits pursuant to the Benefit Options, the Plan may also provide other benefits to Participants and their Dependents including, but not limited to, well-being programs, and permitted incentive rewards for well-being initiatives.

6.02 Terms and Limitation on Benefits. Coverage, benefit terms, exclusions, and limitations for available benefits shall be as set forth in such Benefit Option's Coverage Document to the extent not addressed herein.

6.03 Post-termination Participation. Post-termination participation in available Benefit Options shall be governed by such Benefit Option's Coverage Document to the extent not addressed herein.

6.04 Rules and Regulations. Wespath shall establish all necessary rules, regulations, and procedures for the proper administration of any Benefit Option established or offered hereunder. Any and all specific Benefit Options may be created, amended or terminated by Wespath at any time in its sole discretion, provided that reasonable allowance is made for prior notification to the Plan Sponsors and Participants therein as appropriate. Wespath is not required to notify Plan

Sponsors or Participants of amendments necessitated by changes in applicable law or regulations.

6.05 Coordination of Benefits. The Plan shall coordinate benefits when a Participant or Dependent is eligible for benefits under more than one group health plan. The specific coordination of benefits provisions are set forth in the Plan's *Summary Plan Description* or applicable benefits booklet.

6.06 Equitable Recovery. The Plan shall be subrogated for and, as permitted by the holding in *Sereboff* and under theories of equitable recovery based on an agreement between the Plan and individuals covered under the Plan, the Plan shall be entitled to, through an equitable lien based on such agreement, and shall succeed to all rights of reimbursement and recovery for, the reasonable value of any services and payments for benefits that the Plan has provided to Participants, Spouses and Dependents, from any or all of the following:

- (a) Third parties including any person alleged to have caused a covered Participant or Dependent to suffer injuries or damages;
- (b) Any person or entity who is or may be obligated to provide benefits or payments to a covered Participant or Dependent, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators; and
- (c) Any person who or entity that is liable for payment to a covered Participant or Dependent on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

- (d) A Participant shall cooperate with the Plan in a timely manner in protecting the equitable rights to subrogation and reimbursement, including but not limited to:
 - (i) providing any relevant information requested by the Plan,
 - (ii) signing and delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
 - (iii) responding to requests for information about any accident or injuries,
 - (iv) appearing at depositions and in court; and
 - (v) obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.
- (e) Failure by a Participant to cooperate in the manner described in Section 6.07(d) shall be deemed a breach of contract, and the Plan Administrator may terminate the coverage of the Participant or Dependent and institute legal action.

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- (f) Court costs and attorneys' fees shall not be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan shall not be required to participate in or pay court costs or attorneys' fees to the attorney hired by a Participant or Dependent to pursue his or her damage or personal injury claim.
- (g) Regardless of whether a Participant or Dependent has been fully compensated or made whole, the Plan may collect from Participants and Dependents the proceeds of any full or partial recovery that a Participant or Dependent or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available in equity for the Plan's recovery shall include any and all settlements or judgments, including, but not limited to, those designated as pain and suffering, non-economic damages, and/or general damages only.
- (h) Participants and Dependents are deemed to agree that if they receive any payment from any purportedly responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability) or judgment, the Participant or Dependent will serve as a constructive trustee over the funds. Further, Participants and Dependents are deemed to agree that failure to hold such funds in trust will be deemed a breach of the Participant's or Dependent's duties hereunder.
- (i) To the extent permitted by law, the Plan shall be entitled to recover reasonable attorneys' fees from a Participant or Dependent incurred in collecting from the Participant or Dependent any funds held by the Participant or Dependent that he or she recovered from any Third Party.
- (j) To the extent permitted by law, the Plan may set off from any future benefits otherwise allowed and payable by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.
- (k) Participants and Dependents shall not accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Participant or Dependent do anything to prejudice the Plan's rights under this section. Participants and Dependents have no authority to sign a settlement or release with any Third Party for monies to which the Plan may be entitled.
- (l) Participants will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.
- (m) The Plan's rights under this Section will be considered as the first priority claim against Third Parties, including tortfeasors (those liable for injuries) from whom Participants and Dependents are seeking recovery to be paid before any other of the Participant's or Dependents' claims are paid.

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- (n) The Plan's rights under this Section will not be reduced due to the Participant's or Dependent's negligence.
- (o) The Plan may, at its discretion, take necessary and appropriate action to preserve its rights under this Section, including filing suit in the Participant's name. The Plan shall not be obligated, however, to pursue this right independently or on behalf of the Participant or Dependent.
- (p) If the injury or condition giving rise to subrogation or reimbursement involves a minor child, the terms of this Section shall apply to the parents or guardian of the minor child.
- (q) If the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Participant or Dependent, this Section shall apply to the personal representative of the decedent.

Article VII – Health Care FSA

7.01 In General. The purpose of the Health Care FSA is to enable Active Employees who elect to participate in the Health Care FSA to receive reimbursement or payment of certain health expenses subject to the terms, conditions, and limitations set forth herein. It is intended that the Health Care FSA qualify as an accident and health plan within the meaning of §105(e) of the Code and that the benefits payable under the Health Care FSA be eligible for exclusion from gross taxable income under §105(b) of the Code. An Active Employee may elect to participate in this Health Care FSA by electing on an approved Form to receive Benefits in the form of reimbursements for Medical Expenses and pay the cost for such Benefits with before-tax Contributions that are allocated to the Participant’s Health Care FSA.

7.02 Definitions. For purposes of this Article, the following special definitions shall apply:

- (a) “Benefits” means reimbursement benefits for Medical Expenses under this Health Care FSA.
- (b) “Carryover” means the amount that remains in a Participant’s Health Care FSA at the end of any Plan Year which, up to the maximum carryover under Code section 125(i) for that plan year as announced by the Internal Revenue Service and as determined by the Plan Administrator, shall be available during the following Plan Year. If the Participant did not elect to contribute to a Health Care FSA for that Plan Year, the Carryover shall still be available for that Plan Year, but any balance of the Carryover that is unused at the end of that Plan Year shall not be available during any future Plan Year. Notwithstanding anything herein to the contrary, for 2021 and 2022 only, “Carryover” means the entire amount that remains in a Participant’s Health Care FSA at the end of the Prior Plan Year, and the Carryover shall apply regardless of a Participant’s election for 2021 or 2022.
- (c) “Dependent” means a dependent as defined in §152 of the Code. Any child to whom §152(e) of the Code applies shall be treated as a Dependent of both parents. In addition, “Dependent” includes a Participant’s child who has not attained age 27 as of the end of the Plan Year consistent with the tax exclusions for coverage and reimbursements under §105 and §106 of the Code.
- (d) “Medical Expenses” means expenses incurred by a Participant, a Participant’s Spouse or a Participant’s Dependents for medical care, as defined in §213(d) of the Code (without regard to the limitations contained in §213(a) of the Code) and applicable Treasury Regulations and Internal Revenue Service guidance, but only to the extent that: (1) the Participant submits a Claim for reimbursement of such expense incurred during the Period of Coverage and submitted by the end of the Run-out Period described in Section 7.05 or the period described in Section 7.06; and (2) such expense is not covered, paid, or reimbursed under a Benefit Option or otherwise (i.e., through other health coverage). Medical Expenses shall not include:
 - (i) an expense incurred for the payment of Required Contributions under the Plan or any premiums under any other health coverage or health insurance plan; or

- (ii) expenses for qualified long-term care services [as defined by §7702B(c) of the Code] and premiums for long-term care insurance.

7.03 Limitation on Benefits.

- (a) **Covered Expenses.** The Health Care FSA shall only cover Medical Expenses incurred during the Period of Coverage and shall only cover Medical Expenses incurred from Contributions made to this Health Care FSA by the Active Employee during such Period of Coverage plus any Carryover. Medical Expenses shall be considered incurred when the medical care or service giving rise to the Medical Expense is provided and not when the Active Employee is billed, charged for, or pays for the Medical Expenses.
- (b) **Amount of Benefits.** The maximum amount that an Active Participant may elect to contribute to his or her Health Care FSA in any Plan Year shall be \$3,400 pursuant to §125(i) of the Code, or a lesser amount as determined by the Plan Administrator in accordance with applicable law. The maximum amount that an Active Participant can have available in any Plan Year will be the amount of Contributions elected plus any Carryover. The minimum amount that an Active Participant may elect to contribute to his or her Health Care FSA in any Plan Year shall be \$300 or as determined by the Plan Administrator in accordance with applicable law. The Plan Administrator may change the maximum and minimum amounts for any Period of Coverage without the need to amend the Plan; provided that the maximum dollar limit shall not exceed the maximum amount permitted under §125(i) of the Code, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2), plus any Carryover. Any such changes shall be communicated to Active Employees through the salary reduction agreement or another document.
- (c) **Uniform Coverage.** Reimbursement for Medical Expenses up to the amount elected by an Active Participant for a Period of Coverage shall be available at all times during the Period of Coverage (reduced by prior reimbursements during the Period of Coverage) regardless of the actual amounts by which an Active Employee's salary has been reduced and the amount that the Active Employee has contributed.
- (d) **Repayment of Excess Benefits.** In the event that, as of the end of any Plan Year, the Plan Administrator determines that an Active Employee has received payments under this Plan that exceed the amount that Active Employee elected to contribute for that Plan Year, the Plan Administrator shall give the Active Employee prompt written notice of any such excess amount, and the Active Employee shall repay the amount of such excess to the Plan Administrator or Recordkeeper within 60 days of such notification.
- (e) **Forfeitures.** Amounts that remain in a Participant's Health Care FSA in excess of the allowed Carryover shall be forfeited after payment of all timely presented eligible Claims for Medical Expenses incurred during the applicable Period of Coverage, pursuant to Section 7.05 below. Forfeited amounts shall accrue to the Plan.

7.04 Eligibility, Enrollment and Termination. All Active Employees in the Plan may elect to contribute to a Health Care FSA under this Health Care FSA. Enrollment and termination of participation under the Plan shall constitute enrollment and termination of participation under this Health Care FSA.

7.05 Claims for Benefits.

- (a) ***Claims for Reimbursement Benefits.*** Claims for Health Care FSA Benefits totaling a minimum amount as determined by the Plan Administrator may be made at any time during the Period of Coverage.
- (b) ***Prior Payment Unnecessary.*** Active Employees need not actually make payment for reimbursable Medical Expenses before being reimbursed for them under the Plan. However, the Plan Administrator may require verification that expenses have been incurred.
- (c) ***Claim Substantiation.*** The Plan Administrator or Claim Administrator shall require an Active Employee to substantiate claims for Health Care FSA Benefits under the Plan by submitting an appropriate Claim Form to the Plan Administrator or Claim Administrator, in such manner and form as prescribed by the Plan Administrator or Claim Administrator, setting forth:
 - (i) the individual on whose behalf Medical Expenses have been incurred;
 - (ii) the nature and date of such Medical Expenses;
 - (iii) the amount of the requested reimbursement; and
 - (iv) a statement that such Medical Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

All Claims for Medical Expenses shall be substantiated by copies of invoices, explanations of benefits, bills, receipts or other statements, or electronic evidence from a provider or other third party showing that the Medical Expenses have been incurred, when they were incurred and the amount of such Medical Expenses, together with any additional documentation that the Plan Administrator or Claim Administrator may request.

- (d) ***Time Limit on Claiming Benefits.*** The Plan Administrator shall only reimburse Claims for Medical Expenses if the Active Employee presents eligible Claims during the Period of Coverage or before April 30th of the year that follows the applicable Plan Year. This additional time period is called the “Run-Out Period.” In its discretion, the Plan Administrator may treat reimbursements of Claims for expenses incurred in the current Plan Year as reimbursed first from unused amounts credited for the current Plan Year and, only after exhausting these current Plan Year amounts, as then reimbursed from unused Carryover amounts from the preceding Plan Year. Notwithstanding anything

herein to the contrary, the Run-Out Period for Claims incurred during 2019 is extended to December 31, 2020.

7.06 Reimbursements upon Termination of Participation. An Active Employee who has a Termination of Employment may no longer make Contributions nor have Contributions made to the Health Care FSA on his or her behalf. However, he or she (or, in the event of termination of employment due to death, his or her Spouse and Dependents) may continue to receive Benefits under the Health Care FSA for Claims incurred prior to the Termination of Employment. Such payments to a Terminated Participant shall be:

- (a) limited in amount to the balance remaining in the Terminated Participant's Health Care FSA at the time of Termination of Employment minus any subsequent reimbursements, and
- (b) limited in time to 90 days after the last day of the month in which the Termination of Employment occurs.

Claims submitted more than 90 days after the last day of the month in which the Termination of Employment shall not be reimbursed; any amounts remaining in the Health Care FSA at the end of this post-termination Run-Out period shall be forfeited to the Plan pursuant to Section 7.03(e).

7.07 Rules and Regulations. The Plan Administrator shall establish all necessary rules, regulations, and procedures for the proper administration of this Health Care FSA.

7.08 Recordkeeper. Wespath, in its discretion, may delegate administrative and recordkeeping duties with respect to the Health Care FSA to a third-party agent who shall be called the Recordkeeper of the Health Care FSA. The Recordkeeper shall account for the Health Care FSA balance of each Participant. The Recordkeeper may also serve as Claim Administrator for the Health Care FSA.

Article VIII – Dependent Care FSA

8.01 In General. The purpose of the Dependent Care FSA is to enable eligible Employees to receive reimbursement of certain dependent care expenses subject to the terms, conditions, and limitations set forth herein. It is intended that the Dependent Care FSA qualify as a dependent care assistance program within the meaning of §129(d) of the Code and that the benefits payable under the Dependent Care FSA be eligible for exclusion from gross income under §129(a) of the Code. Participants covered by this Dependent Care FSA may submit Claims for reimbursement of a Participant's eligible covered Dependent Care Expenses from Contributions allocated to the Participant's Individual Benefit Account for Dependent Care Benefits.

8.02 Definitions. For purposes of this Article VIII, the following special definitions shall apply:

- (a) "Benefits" means reimbursement benefits for Dependent Care Expenses under this Dependent Care Program.
- (b) "Carryover" means, for 2021 and 2022 only, the entire amount that remains in a Participant's Dependent Care FSA at the end of the Prior Plan Year. No Carryover shall apply for years other than 2021 and 2022.
- (c) Notwithstanding Section 2.25, for the purposes of this Article VIII the term "Dependent" means an individual who is:
 - (i) a dependent (as defined in §152 of the Code) of a Participant: (1) who is physically or mentally incapable of caring for himself or herself, or (2) who is under the age of 13 and with respect to whom the Participant is entitled to a deduction under §151(c) of the Code; or
 - (ii) a dependent (as defined in §152 of the Code) of the Spouse of a Participant, who is physically or mentally incapable of caring for himself or herself.

Notwithstanding anything herein to the contrary, for 2020 and 2021 only, "age of 14" shall be substituted for "age of 13" in subsection (i) above to the extent allowed by Section 214(d) of the Taxpayer Certainty and Disaster Relief Act of 2020 within the Consolidated Appropriations Act, 2021.

- (d) "Earned Income" means wages, salaries, tips and other compensation, plus net earnings from self-employment, computed without regard to any community property laws and excluding amounts received as a pension or annuity, or paid or incurred by an employer for dependent care assistance. A Participant's Spouse who is either a student or physically or mentally incapable of caring for himself or herself shall be deemed, for each month during which such Spouse is either a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, to be gainfully employed and to have Earned Income of not less than:

- (i) \$250 per month, if the Participant has only one Dependent for the Period of Coverage; or
 - (ii) \$500 per month, if the Participant has two or more Dependents for the Period of Coverage; or
 - (iii) such other dollar amounts as may be permitted under §21(d) of the Code which are hereby incorporated into the Dependent Care FSA by reference.
- (e) “Dependent Care Expenses” means expenses incurred by a Participant during a Period of Coverage that are: (1) incurred for the care of a Dependent of the Participant or for related household services; (2) paid or payable to a Dependent Care Service Provider; (3) incurred to enable the Participant to be gainfully employed for any period during which there are one or more Dependents with respect to the Participant. Dependent Care Expenses shall not include any expenses for which: (1) the Participant does not submit a Claim for during the Period of Coverage or the Run-Out Period described in Section 8.08 or the period described in 8.09; (2) a deduction or credit is claimed on the Participant’s income tax return; (3) reimbursement or payment is received under another dependent care assistance program (other than this Dependent Care FSA); or (4) expenses are incurred for services performed outside the Participant’s household for the care of a Dependent unless such Dependent is described in Section 8.02(c)(ii), above, or regularly spends at least eight hours each day in the Participant’s household; provided, however, such terms shall not include any amount paid for services outside the Participant’s household at a camp where the Dependent stays overnight. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.
- (f) “Dependent Care Service Provider” means an individual operating a dependent care center (as defined in §21(b)(2)(D) of the Code) that: (1) receives a fee or grant for providing services described in Section 8.02(e) to six or more individuals (other than individuals who reside at the dependent care center); and (2) complies with all applicable laws and regulations of a State or local government (as required by §21(b)(2)(D) of the Code). A Dependent Care Service Provider shall not include an individual (as defined in §129(c) of the Code) who is: (1) a dependent with respect to whom the Participant or the Participant’s Spouse is entitled to claim an exemption under §151(c) of the Code; or (2) a son, daughter, stepson or stepdaughter of the Participant under the age of 19.

8.03 Limitation on Benefits.

- (a) **Coverage.** The Dependent Care FSA shall only cover Dependent Care Expenses incurred during the Period of Coverage and only from Contributions made to this Dependent Care FSA by the Active Employee during such Period of Coverage plus any Carryover. Dependent Care Expenses shall be considered incurred when the Dependent care is provided, and not when the Participant is formally billed or charged for or pays the Dependent Care Expenses.

- (b) ***Amount of Benefits.*** If an Active Employee elects to contribute to a Dependent Care FSA, the minimum amount that the Active Employee may elect to contribute to his or her Dependent Care FSA for any Period of Coverage shall be \$300 or as determined by the Plan Administrator in accordance with applicable law. The maximum amount that an Active Employee can elect to contribute to his or her Dependent Care FSA for a Period of Coverage shall be \$7,500 (unless the Active Employee is married but filing income tax returns separately from his or her Spouse, in which case the maximum amount shall be \$3,750) or as determined by the Plan Administrator in accordance with applicable law. Notwithstanding anything in the Plan to the contrary, the Plan Administrator may change a Participant's election to contribute to a Dependent Care FSA at any time, including during a Period of Coverage, as requested by a Plan Sponsor to comply with §129(d) of the Code. The amount payable for a particular Dependent Care FSA Benefit at any time may not exceed the contribution balance of the Participant's Dependent Care FSA at the time the Participant submits his or her Claim for such Benefit, including any Carryover. If Claims for amounts in excess of such balance are made at any time, such Claims may be paid when and if further Employee Contributions or Plan Sponsor Contributions allocable to such Participant's Dependent Care FSA are made during the applicable Period of Coverage.
- (c) ***Repayment of Excess Benefits.*** If at any time during the Period of Coverage, the Plan Administrator determines that an Active Employee has received payments under this Dependent Care FSA that exceed the amount the Active Employee has contributed to his or her Dependent Care FSA, the Plan Administrator shall give the Active Employee prompt written notice of any such excess amount, and the Active Employee shall repay the amount of such excess to the Plan Administrator or Recordkeeper within 60 days of such notification.
- (d) ***Forfeitures.*** Amounts that remain in a Participant's Dependent Care FSA in excess of the allowed Carryover shall be forfeited after payment of all timely presented eligible Claims for Dependent Care Expenses incurred during the applicable Period of Coverage, pursuant to Section 8.08. Forfeited amounts shall accrue to the Plan.

8.04 Eligibility, Enrollment and Termination. All Active Employees in the Plan may elect to contribute to a Dependent Care FSA. Enrollment and termination of participation under the Plan shall constitute enrollment and termination of participation under this Dependent Care FSA.

8.05 Further Limitations. The amount of Benefits payable to a Participant during any Plan Year shall not exceed:

- (a) in the case of a Participant who is not married at the close of such year, the Earned Income of such Participant for such year; or
- (b) in the case of a Participant who is married at the close of such Plan Year, the lesser of:
 - (i) the Earned Income of such Participant for such year; or

- (ii) the Earned Income of the Spouse of such Participant for such Plan Year.

8.06 Prohibition of Certain Payments. No Benefits shall be paid to a Participant during any taxable year of such Participant to reimburse Dependent Care Expenses paid to an individual:

- (a) with respect to whom, for such taxable year, a deduction is allowable under Code §151(e) (relating to personal exemptions for Dependents) to such Participant or his or her Spouse; or
- (b) who is a child of such Participant [within the meaning of Code §151(e)(3)] under the age of 19 at the close of such taxable year.

8.07 Services Outside the Household.

- (a) ***Dependent Care Centers.*** Benefits shall be paid for services provided outside a Participant's household by a facility that provides care for more than six individuals other than individuals who reside at the facility, and receives a fee, payment or grant for providing services for any of the individuals, only if:
 - (i) such facility complies with all applicable laws and regulations of a state or unit of local government; and
 - (ii) the requirements of Section 8.07(b) are met.
- (b) ***Certain Dependents.*** Benefits shall not be paid for services outside a Participant's household unless the services are provided for the care of: (1) a Dependent within the meaning of Section 8.02(c)(i); or (2) any other Dependent who regularly spends at least eight hours each day in the Participant's household.

8.08 Claims for Benefits.

- (a) ***Claims for Reimbursement Benefits.*** Claims for Dependent Care Benefits may be made at any time during a Period of Coverage and the applicable Run-out Period.
- (b) ***Prior Payment Unnecessary.*** Participants need not actually make payment for reimbursable Dependent Care Expenses before being reimbursed for them under the Dependent Care FSA. However, the Plan Administrator may require verification that Dependent Care Expenses have been properly incurred.
- (c) ***Claim Substantiation.*** The Plan Administrator or Claim Administrator shall require a Participant to substantiate Claims for Dependent Care FSA Benefits under the Plan. Claimants shall substantiate all Claims for reimbursement of Dependent Care Expenses with copies of bills or receipts. Where necessary and appropriate, the Plan Administrator may in its discretion waive such requirements, but in so doing shall always act in a uniform and nondiscriminatory manner.

- (d) ***Time Limit on Claiming Benefits.*** The Plan Administrator shall only reimburse Claims for Dependent Care FSA Benefits if the Participant presents such Claims during the Period of Coverage or before April 30th of the year that follows the applicable Plan Year. This additional time period is called the “Run-Out Period.” Notwithstanding anything herein to the contrary, the Run-Out Period for Claims incurred during 2019 is extended to December 31, 2020.

8.09 Post-Termination. Post-termination participation shall be determined in accordance with the rules and regulations established by the Plan Administrator. Generally, an Active Employee who has a Termination of Employment may no longer make Contributions nor have Contributions made to the Dependent Care FSA on his or her behalf. However, he or she may continue to receive Benefits under the Dependent Care FSA for Claims incurred prior to the Termination of Employment. Such Dependent Care FSA Benefit payments to a Terminated Participant shall be:

- (c) limited in amount to the contributed balance remaining in the Terminated Participant’s Dependent Care FSA at the time of Termination of Employment minus any subsequent reimbursements; and
- (d) limited in time to 90 days after the last day of the month in which the Termination of Employment occurs.

Claims submitted more than 90 days after the last day of the month in which the Termination of Employment occurs shall not be reimbursed; any amounts remaining in the Dependent Care FSA at the end of this post-termination Run-out Period shall be forfeited to the Plan pursuant to Section 8.03(d).

8.10 Rules and Regulations. The Plan Administrator shall establish all necessary rules, regulations, and procedures for the proper administration of this Dependent Care FSA.

8.11 Recordkeeper. Wespath, in its discretion, may delegate administrative and recordkeeping duties with respect to the Dependent Care FSA to an agent which shall be called the Recordkeeper of the Dependent Care FSA. The Recordkeeper shall account for the Dependent Care FSA balance of each Participant. The Recordkeeper may also serve as Claim Administrator for the Dependent Care FSA.

Article IX - Health Reimbursement Accounts

- 9.01 In General.** A Health Reimbursement Account (HRA, also called a Health Reimbursement Arrangement) is intended to permit an eligible HRA Participant, as described in Section 9.04 below, to obtain reimbursement of Medical Care Expenses from the HRA on a nontaxable basis. Capitalized terms used in this Article IX that are not otherwise defined in the Plan shall have the meanings set forth in Section 9.03.
- 9.02 Legal Status.** The HRA is intended to qualify as an employer-provided medical reimbursement plan under Code §105 and Code §106 and the Treasury Regulations issued thereunder, and as a health reimbursement arrangement as defined under *IRS Notice 2002-45*, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the HRA are intended to be eligible for exclusion from HRA Participants' gross income under Code §105(b).
- 9.03 Definitions.**
- (a) "Benefits" means the reimbursement benefits for Medical Care Expenses described under Section 9.06.
 - (b) "Eligible Employee" means an Employee as described in Section 2.32 of the Plan eligible to participate in the Plan, as described in Article III, covered in an HRA-eligible Benefit Option as determined by the Plan Administrator and the elections of the Plan Sponsor in its Adoption Agreement, and eligible to participate in the HRA, as provided in Section 9.04.
 - (c) "Eligible Medical Care Expenses" has the meaning defined in Section 9.06(a).
 - (d) "Employer" for the purposes of the HRA and this Article IX means a Participant's Plan Sponsor.
 - (e) "HRA Claims Administrator" means the third-party claims processing administrator chosen and engaged by Wespeth. Wespeth may change the HRA Claims Administrator at any time without notice to Participants.
 - (f) "HRA Dependent" means any individual who qualifies as an eligible dependent of a Participant under an HRA-eligible Benefit Option under the Plan. Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child or eligible spouse does not meet the definition of "Dependent." The HRA does not cover Medical Care Expenses of dependents as defined in Code §152 who are not covered in an HRA-eligible Benefit Option under the Plan.
 - (g) "HRA Participant" means a person who is an Eligible Employee and who is participating in an HRA-eligible Benefit Option as determined by the Plan Administrator and the election of the Plan Sponsor on its Adoption Agreement, *and* an HRA in accordance with the provisions of this Article IX.

- (h) “Retiree HRA” means the post-termination health care reimbursement arrangement maintained by Wespath described in Section 9.07.
- (i) “Retired HRA Participant” means a former Employee who remains an “HRA Participant” for only the limited purpose of continued eligibility for benefits in retirement in accordance with Section 9.07.
- (j) “Spouse” means an individual who is legally married to an HRA Participant or Retired HRA Participant as determined under applicable state law (and who is treated as a spouse under the Code or is otherwise permitted to be covered in an HRA under *IRS Notice 2002-45* and other IRS guidance). To be eligible under the HRA for claims reimbursement, an HRA Participant’s Spouse must also be covered in an HRA-eligible Benefit Option as determined by the Plan Administrator and the election of the Plan Sponsor. Expenses incurred by Spouses who are not covered in an HRA-eligible Benefit Option under the Plan are not eligible for reimbursement.

9.04 Eligibility to Participate. An individual is eligible to participate in the HRA if he or she is a Participant in the Plan and has elected and is enrolled in an HRA-eligible Benefit Option, as determined by the Plan Administrator and the Plan Sponsor’s elections on its Adoption Agreement under the Plan. Once Wespath has determined that an Employee has met the HRA’s eligibility requirements, the Employee’s coverage in the HRA will commence.

- (a) ***Termination of Participation.*** Reimbursements from the Plan after termination of participation will be made pursuant to Section 9.07.
- (b) ***Participation Following a Termination of Participation.*** If a Participant becomes a Terminated Participant for any reason (including but not limited to disability, retirement, layoff or voluntary resignation) and then is rehired, the Participant will be considered a new HRA Participant.
- (c) ***FMLA and USERRA Leaves of Absence.*** Notwithstanding any provision to the contrary in this Article, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, Wespath will continue to maintain the Participant’s Benefits on the same terms and conditions as if the Participant were still an active Employee.
- (d) ***Effective date of Participation.*** An Employee who first becomes eligible to participate in the HRA will commence participation on the first day after the eligibility requirements have been satisfied. Once enrolled, the Employee’s participation will continue year-to-year until the Employee’s participation ceases pursuant to Section 9.04(a).

9.05 Benefits Offered.

- (a) ***In General.*** When an Eligible Employee becomes an HRA Participant in accordance with Section 9.04, an HRA will be established for such Participant to receive HRA Benefits in the form of reimbursements for Eligible Medical Care Expenses, as described in Section 9.06. In no event shall HRA Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical Care Expenses.
- (b) ***Employer and Participant Contributions***
 - (i) *Employer Contributions.* Contributions from the Plan and, if applicable, from the Plan Sponsor (i.e., the Employer for purposes of the HRA) shall fund the full amount of the HRAs.
 - (ii) *Participant Contributions.* Participant contributions to HRAs are not permitted.
 - (iii) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions or otherwise under a cafeteria plan.
 - (iv) *Administrative Expenses.* Necessary administrative expenses may be deducted from the Participant's account balance as determined by the Plan Administrator.

9.06 HRA Benefits. The HRA will reimburse HRA Participants for Eligible Medical Care Expenses up to the unused amount in the Participant's HRA, as set forth and adjusted under Section 9.06(c).

- (a) **Eligible Medical Care Expenses.** Under the HRA, an HRA Participant may receive reimbursement for Eligible Medical Care Expenses incurred during a Period of Coverage. The following apply:
 - (i) *Incurred.* An Eligible Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Expenses incurred before a Participant first becomes covered by the Plan are not Eligible Medical Care Expenses.
 - (ii) *Eligible Medical Care Expenses Generally.* "Eligible Medical Care Expenses" means expenses incurred by an HRA Participant or his or her Spouse or HRA Dependents for medical care, as defined in Code §213(d) (without regard to the limitations contained in §213(a) of the Code) and applicable Treasury Regulations and Internal Revenue Service guidance. Additionally, and *only with respect to Retired HRA Participants with Retiree HRA Accounts*, Eligible Medical Care Expenses include premiums for long-term care insurance; individual health, dental and vision insurance policies; and Medicare Part B. Reimbursements due for Eligible Medical Care Expenses incurred by the HRA

Participant or the HRA Participant's Spouse or HRA Dependents shall be charged against the HRA Participant's HRA.

- (iii) *Expenses Cannot Be Reimbursed or Reimbursable from Another Source.* Eligible Medical Care Expenses can only be reimbursed to the extent that the HRA Participant or other eligible person incurring the Eligible Medical Care Expense is not reimbursed for the expense (nor is the expense reimbursable) through a Benefit Option under the Plan, other insurance, or any other accident or health plan. Notwithstanding the preceding sentence, if the "other health plan" is the Health FSA, Section 9.06(g) shall govern the reimbursement. If only a portion of an Eligible Medical Care Expense has been reimbursed elsewhere (e.g., because the Benefit Option or other coverage or insurance imposes co-payment, coinsurance or deductible limitations), the HRA can reimburse the remaining portion of such Eligible Medical Care Expense if it otherwise meets the requirements of this Section 9.06(a).

- (b) *Maximum Benefits.*
 - (i) *Maximum Benefits.* The maximum annual dollar amount that may be credited to an HRA Account for a HRA Participant for an entire Period of Coverage shall be as determined under the applicable policy established by Wespath annually before the beginning of each Plan Year. In addition, the HRA Participant's Plan Sponsor may contribute Employer contributions to the HRA Participant's HRA Account under its own written policy that is uniform and nondiscriminatory among the Plan Sponsor's HRA Participants. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 9.06(d).
 - (ii) *Changes.* For each Plan Year, the maximum dollar limit may be changed once annually by Wespath and shall be communicated to HRA Participants and Eligible Employees through an enrollment form, other enrollment and Annual Election materials, the *Summary Plan Description* (SPD) or another document. In addition, a Plan Sponsor may, in its discretion, contribute additional Employer contributions to its HRA Participants' HRA Accounts on a uniform and nondiscriminatory basis pursuant to established Plan Sponsor policies.

- (c) *Establishment of Account.* Wespath will establish and maintain an HRA with respect to each HRA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.
 - (i) *Crediting of Accounts.* At the beginning of each Plan Year, the HRA Participant will receive a contribution, as determined by Wespath and, if applicable, the Plan Sponsor, to the HRA Participant's HRA.
 - (ii) *Debiting of Accounts.* An HRA Participant's HRA will be debited during each Period of Coverage for any reimbursement of Eligible Medical Care Expenses

incurred during the Period of Coverage and, if necessary, for administrative expenses.

- (iii) **Available Amount.** The amount available for reimbursement of Eligible Medical Care Expenses is the amount credited to the Participant's HRA under Section 9.06(c)(i) reduced by prior reimbursements debited under Section 9.06(c)(ii) and any administrative expenses.
- (d) **Carryover of Accounts.** If any balance remains in the Participant's HRA for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the HRA Participant for Eligible Medical Care Expenses incurred during a subsequent Period of Coverage.
- (e) **Reimbursement Procedure.**
 - (i) **Claims Substantiation.** An HRA Participant who seeks Benefits may apply for reimbursement by submitting an appropriate Claim Form to the Plan Administrator or HRA Claim Administrator, in such manner and form as prescribed by the Plan Administrator or HRA Claim Administrator, setting forth:
 - (A) the individual on whose behalf expenses have been incurred;
 - (B) the nature and date of such expenses;
 - (C) the amount of the requested reimbursement; and
 - (D) a statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such expenses has been exhausted.

All Claims shall be substantiated by copies of invoices, explanations of benefits, bills, receipts, electronic evidence, or other statements from an independent third party showing that the expenses have been incurred, when they were incurred, and the amount of such expenses, together with any additional documentation that the Plan Administrator or HRA Claim Administrator may reasonably request.

 - (ii) **Claims Denied.** Claims for reimbursement that are denied are subject to the appeals procedure in Section 13.06.
- (f) **Opt Out.** In accordance with IRS *Notice 2013-54*, a Terminated Participant as described in Section 2.77, an HRA Participant who otherwise incurs a Termination of Employment may opt out of the HRA at the time of Termination, or at other times permitted by the Plan, pursuant to an HRA opt-out policy established by Wespath that complies with *Notice 2013-54* and the PPACA. Similarly, a Retired HRA Participant may opt out of the HRA at the time of Retirement, or at other times permitted by the Plan, pursuant to an HRA opt-out policy established by Wespath that complies with *Notice 2013-54* and the PPACA.

- (g) ***Coordination of Benefits; Health FSA to Reimburse First.*** HRA Benefits under the HRA are intended to pay benefits solely for Eligible Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from the HRA. Without limiting the foregoing, if the Participant's Eligible Medical Care Expenses are covered by both this HRA and by the Health Care FSA (if the Participant has elected the Health Care FSA), then the HRA is not available for reimbursement of such Eligible Medical Care Expenses until after amounts available for reimbursement under the Health Care FSA are exhausted first.

9.07 Impact of Termination of HRA Participation or Loss of Eligibility on HRA Balance.

- (a) An HRA Participant's coverage will terminate upon Termination of Employment, becoming a Terminated Participant or other loss of eligibility and all Eligible Medical Care Expenses incurred up until such time shall be eligible for reimbursement under the terms of this Article IX. If any balance remains in a Terminated or ineligible Participant's account, the funds will be handled as set forth in the *Summary Plan Description*, which is hereby incorporated by reference herein.
- (b) ***Retiree HRA.*** An HRA Participant who retires pursuant to the retirement eligibility rules of the Plan and his or her Plan Sponsor shall have any remaining balance in his or her HRA converted and transferred to a Retiree HRA. A Retired HRA Participant may be reimbursed from his or her Retiree HRA for Eligible Medical Care Expenses [as described in Section 9.06(a)] until such Retiree HRA is exhausted. Amounts are carried over from Plan Year to Plan Year as long as the Retired HRA Participant remains retired and has not died. Upon the death of a Retired HRA Participant, if such deceased Retired HRA Participant has an eligible surviving Spouse or eligible surviving HRA Dependents, the eligible survivors may be reimbursed from the Retiree HRA of the deceased Retired HRA Participant for Eligible Medical Care Expenses until the earliest of the following: such Retiree HRA is exhausted, such survivors die, or such survivors have ceased to be Participants in a Benefit Option for more than one (1) year. If a Retired HRA Participant dies with a balance in his or her Retiree HRA and has no eligible surviving Spouse or HRA Dependents, the balance of such Retiree HRA is forfeited. A Retired HRA Participant who becomes a participant in the Medicare Marketplace and HRA Program with an HRA under that program pursuant to the elections of his or her Plan Sponsor shall continue to be considered a Retired HRA Participant under this Article IX and shall remain eligible for reimbursement from his or her Retiree HRA. The HRA Participant may seek reimbursement from his or her Retiree HRA and his or her HRA under the Medicare Marketplace and HRA Program in the order and manner established by the Plan Administrator from time to time, in coordination with the applicable claims administrators. Similarly, Spouses and other HRA Dependents of Retired HRA Participants who become eligible Dependents under the Medicare Marketplace and HRA Program may continue to benefit from a Retiree HRA where applicable.
- (c) ***Continuation Coverage.*** Notwithstanding any provision to the contrary in this Plan, to the extent required by Continuation Coverage, the HRA Participant and his or her Spouse

and HRA Dependents (Continuation Beneficiaries), whose coverage terminates under the Plan because of a qualifying event, shall be given the opportunity to continue the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by the Plan's Continuation Coverage policies. At the beginning of the Plan Year, Continuation Beneficiaries shall be credited with the annual contribution amount that is made available to other HRA Participants and any unused reimbursement amounts from the previous Coverage Period shall be carried over (provided that the applicable Continuation Coverage premium is paid).

9.08 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 HRA Participant, or the amount of HRA Benefits paid or to be paid to an HRA Participant or other person, Wespath shall cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as are necessary in its judgment to correct such HRA, to the extent that it deems administratively possible and otherwise permissible under Code §105, the Treasury Regulations issued thereunder and other applicable law.

9.09 General Provisions

- (a) **Code Compliance.** It is intended that this HRA meet all applicable requirements of the Code, PPACA, all Treasury Regulations issued thereunder and any other applicable IRS guidance. This HRA shall be construed, operated and administered accordingly. In the event of any conflict between any part, clause or provision of this Article IX and the Code or PPACA, the provisions of the Code and PPACA shall be deemed controlling, and any conflicting part, clause or provision of this Article shall be deemed superseded to the extent of the conflict.
- (b) **No Guarantee of Tax Consequences.** Although the HRA is designed to comply with Code §105 and §106 and *IRS Notice 2002-45* and be a tax-exempt employer-provided health benefit, neither Wespath nor any Plan Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of an HRA Participant under this HRA will be excludable from the HRA Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each HRA Participant to determine whether each payment under the HRA is excludable from the HRA Participant's gross income for federal, state and local income tax purposes, and to notify Wespath if the HRA Participant has any reason to believe that such payment is not so excludable.
- (c) **Indemnification of Employer.** If any HRA Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and such payments do not qualify for such treatment under the Code, such HRA Participant shall indemnify and reimburse Wespath or Plan Sponsor for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.
- (d) **Small Account Balances.** If an HRA Participant's HRA balance falls below a certain threshold established by the Plan Administrator and specified in the Coverage Document, and no additional contributions to the HRA are reasonably expected based

on the HRA Participant's elections, the HRA Participant's HRA balance shall be forfeited. Forfeited amounts shall accrue to the Plan.

Article X - Health Savings Account Program

10.01 In General. The purpose of the Health Savings Account Program is to facilitate pre-tax (or, in certain circumstances, post-tax) contributions to Health Savings Accounts for individuals who satisfy the eligibility requirements under Section 10.03(a). While the HSAs themselves are not part of the Plan (they are established by individuals outside of the Plan, and are administered by a third-party), the Plan permits funding of the HSAs as qualified benefits under the cafeteria plan provisions herein.

10.02 Benefits. A Participant may elect benefits under the Health Savings Account Program by electing salary reduction contributions. A Participant may prospectively change a prior salary reduction election for HSA contributions monthly and may prospectively revoke a prior salary reduction election if they cease to be an HSA-Eligible Individual. In addition, if approved by Wespath, the Plan Sponsor may make contributions to the Health Savings Account for the benefit of HSA-Eligible Individuals (as defined under Section 10.03). Contributions by a Plan Sponsor will not be funded to the extent that a mistaken contribution has been made and has not been repaid by the time the Plan Sponsor would otherwise make such a contribution.

10.03 Terms, Conditions, and Limitations.

- (a) ***Terms of Eligibility.*** Individuals with coverage under a qualified high-deductible health plan Benefit Option (HSA-eligible Benefit Option) of this Plan, as determined by the Plan Administrator, and who satisfy the HSA eligibility requirements under Code §223(c), may participate in the Health Savings Account Program. These individuals are referred to in this Article as HSA-Eligible Individuals. HSA-Eligible Individuals who are Participants and are actively employed may elect to make pre-tax (or post-tax) HSA contributions.
- (b) ***Maximum Benefit.*** The annual contribution for an HSA-Eligible Individual's HSA benefits is equal to the annual benefit amount elected by the HSA-Eligible Individual and includes personal contributions and Employer funding. The amount cannot exceed the statutory maximum amount for HSA contributions applicable to the tier of coverage for the HSA-Eligible Individual's HSA-eligible Benefit Option (e.g., single or p+1/family) for the calendar year in which the contribution is made. In addition, the maximum annual personal contribution is (1) reduced by any Plan Sponsor Contribution made on the HSA-Eligible Individual's behalf; and (2) prorated for the number of months in which the individual is an HSA-Eligible Individual (i.e., has elected qualifying HDHP coverage under this Plan and has no other disqualifying health coverage), if proration is required by Code §223(b).
- (c) ***Limitations.*** If an HSA-Eligible Individual elects to participate in the Health Savings Account Program, then any Health Reimbursement Account or Health Care FSA in which they have any unused balance will be converted by the Plan to a limited-use HRA or FSA, for payment only of vision or dental services until such time as the HSA-Eligible Individual shows necessary documentation to the Plan Administrator or Claim Administrator that the HSA-Eligible Individual has met the IRS minimum deductible

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for the Plan Year. At that time, the HRA or Health Care FSA can be converted to a full-use HRA or FSA.

Article XI – Use and Disclosure of Protected Health Information

The Plan is a “hybrid entity” as that term is defined in the HIPAA regulations. This Article XI shall apply only with respect to benefits under the Plan that constitute a “Health Plan” as defined in Section 11.01(a).

11.01 Definitions. For purposes of this Article XII, the following special definitions shall apply whenever such word or phrase is capitalized and used herein:

- (a) “Health Plan” shall have the same meaning as the term “health plan” in 45 CFR §160.103.
- (b) “Plan Administrative Functions” shall have the same meaning as the term “plan administrative functions” in 45 CFR §164.504(a).
- (c) “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 42 CFR §164.501.
- (d) “Secretary” shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.
- (e) “Summary Health Information” shall have the same meaning as the term “summary health information” in 45 CFR §164.504(a).

11.02 Permitted Uses and Disclosure of Summary Health Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to Wespeth in its role as a Plan Sponsor, or to any other Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

- (a) obtaining premium bids from Health Plans for providing health insurance coverage under the Plan; or
- (b) modifying, amending or terminating its participation in the Plan.

11.03 Permitted Disclosure of Enrollment Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to a Plan Sponsor whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

11.04 Permitted and Required Uses and Disclosure of PHI for Plan Administration. Unless otherwise prohibited by law, and subject to the conditions described in Section 11.05 and obtaining written certification pursuant to Section 11.07, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose PHI to a Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only to carry out Plan Administrative Functions for the Plan. Notwithstanding the provisions of the Plan to the contrary, in no event shall Wespeth be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

11.05 Conditions of Disclosure for Plan Administrative Functions. Each Plan Sponsor agrees that with respect to PHI disclosed to it by the Plan or a health insurance issuer or HMO with respect to the Plan (other than enrollment information and Summary Health Information, which are not subject to the restrictions of Section 11.05), the Plan Sponsor shall:

- (a) not use or disclose the PHI other than as permitted or required by the Plan or as required by law;
- (b) ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- (c) not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for herein of which the Plan Sponsor is aware;
- (e) make available PHI in accordance with 45 CFR §164.524; make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526; and make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- (f) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary upon request for purposes of determining compliance by the Plans with subpart E of 45 CFR §164;
- (g) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made—except that if such return or destruction is not feasible, Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information impossible;
- (h) ensure that there is adequate separation between the Plan and Plan Sponsor in accordance with 45 CFR §504(f)(2)(iii) and Section 11.06; and
- (i) to the extent that the Plan Sponsor creates, receives, maintains, or transmits electronic PHI:
 - (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;
 - (ii) ensure that the adequate separation between the Plan and Plan Sponsor as set forth in 45 CFR §164.504(f)(2)(iii) (and described in Section 11.06 below) is supported by reasonable and appropriate security measures;

- (iii) ensure that any agent to whom it provides this electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- (iv) report to the Plan any security incident of which is becomes aware; provided, however, that the Plan and Plan Sponsor acknowledge and agree that this provision constitutes notice by the Plan Sponsor to the Plan of the ongoing existence and occurrence of attempted by unsuccessful security incidents for which no additional notice to the Plan shall be required (“unsuccessful security incidents” shall include, but not be limited to, pings and other broadcast attacks on the Plan Sponsor’s firewall, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI).

11.06 Adequate Separation. Wespath shall allow access to PHI (including PHI received from a health insurance issuer with respect to the Plan) to the workforce members in certain departments or functions, who are under the control of and specified by Wespath, including certain individuals in Benefit Plans, Customer Service, Human Resources, Compliance, Plan Sponsor Relations, Communications, Finance, Legal Services, Church Relations, and Office Services who are responsible for or support Plan Administrative Functions, members of the Appeals Committee, and individuals in Information Technology who provide technical support to the foregoing. In addition, the workforce includes individuals who perform human resources functions at a Plan Sponsor and are responsible for certain, limited Plan Administrative Functions. Wespath shall only permit disclosures to workforce members under the control of Wespath or a Plan Sponsor, as applicable, who shall have access to PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The permitted employees, classes of employees, or other workforce members shall only have access to and use PHI to the extent necessary to perform the Plan Administrative Functions that Wespath or a Plan Sponsor, as applicable, provides for the Plan. In the event that any of the workforce members do not comply with the provisions of this Article XI, that workforce member shall be subject to disciplinary action and sanctions by Wespath or Plan Sponsor, as applicable, for non-compliance pursuant to Wespath’s or Plan Sponsor’s disciplinary and termination policies and procedures.

11.07 Certification of Plan Sponsor. The Plan, or a health insurance issuer or HMO with respect to the Plan, shall disclose PHI to Wespath or another Plan Sponsor only upon the receipt of a certification by Wespath or the Plan Sponsor, as applicable, that the Plans have been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Wespath or the Plan Sponsor agrees to the conditions of disclosure set forth in Section 11.05.

11.08 Restrictions on Disclosure. Notwithstanding the provisions of this Article XI or the Plan to the contrary, neither the Plan, nor a health insurance issuer or HMO with respect to the Plan shall disclose PHI to Wespath or another Plan Sponsor:

- (a) unless a statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice; or
- (b) for the purpose of employment-related actions or decisions or in connection with any

other benefit or employee benefit plan of Wespeth or Plan Sponsor.

Article XII – Trustee

12.01 Responsibilities of the Trustee. The Trustee shall be responsible to hold the assets of the Plan in trust as set out in the Trust Agreement.

12.02 Powers of the Trustee. The Trustee, in addition to all powers and authorities under common law, statutory authority, and other provisions of the Plan, shall have the power and authority to be exercised in the Trustee's sole discretion to do all such acts and exercise all such rights and privileges, although not specifically mentioned herein, as the Trustee may deem necessary to carry out the purposes of the Trust.

12.03 Services. Nothing herein shall prevent the Trustee from contracting for services with another entity including one that is, with the Trustee, part of a controlled group.

Article XIII – Administration of the Plan

13.01 Powers and Duties of the Plan Administrator. Wespath shall have the power to take all actions required to carry out the provisions of the Plan. Wespath has the power and discretion to construe the terms of the Plan and to determine all questions arising with the administration, interpretation and application of the Plan. Any such determination by Wespath will be conclusive and binding upon all persons. Wespath, in addition to all the powers and authorities under common law, statutory authority and other provisions of the Plan, shall further have the following powers and duties, which shall be exercised in Wespath's discretion to:

- (a) establish procedures, correct any defect, supply any information or reconcile any inconsistency in such manner and to such extent as may be deemed necessary or advisable to carry out the purpose of the Plan;
- (b) determine all questions relating to the eligibility of an Employee to participate or remain a participant hereunder and to receive benefits under the Plan;
- (c) file or cause to be filed all such annual reports, returns, schedules, descriptions, financial statements and other statements as may be required by any federal or state statute, agency or authority;
- (d) obtain from the Plan Sponsors and Employees such information as shall be necessary to the proper administration of the Plan;
- (e) determine the amount, manner and time of payment of benefits hereunder;
- (f) contract with such insurance carriers, Claim Administrators, or other service providers as may be necessary to provide for benefits;
- (g) communicate to any Insurer, Claim Administrator, or other contract service provider of benefits under this Plan in writing all information required to carry out the provisions of the Plan;
- (h) notify the Participants of the Plan in writing of any amendment or termination of the Plan, or of a change in any benefits available under the Plan;
- (i) prescribe such Forms as may be required for Employees to make elections under this Plan;
- (j) maintain all necessary records for the administration of the Plan;
- (k) assist any Employee in understanding his or her rights, benefits or elections under the Plan;
- (l) prepare and distribute information explaining the Plan;

- (m) construe and interpret the provisions of the Plan; to decide the validity of any election or designation made under the Plan, and the amount, manner and time of any allocation to accounts or payment of benefits hereunder; and to make factual determinations necessary or appropriate for such decisions or determinations;
- (n) appoint or employ advisors including legal and actuarial counsel (who may also be counsel to the Trustee) to render advice with regard to any responsibility of Wespath under the Plan or to assist in the administration of the Plan;
- (o) adopt reasonable procedures for determining whether any order, judgment or decree constitutes a QMCSO or other applicable support order;
- (p) settle, compromise or submit to arbitration any claims, debts or damages due or owing to or from the Plan, to commence or defend suits or legal or administrative proceedings, and to represent the Plan in all suits and legal and administrative proceedings, and to comply with judicial and administrative orders, decrees, judgments, summons, subpoenas, levies and other writs or instruments of judicial or administrative process, without regard to their potential vulnerability to challenge on jurisdictional or other legal grounds, all within the sole discretion of Wespath;
- (q) enter into a contract or an agreement with one or more insurance companies for the purchase from such Plan assets of one or more insurance contracts that provide benefits to Participants under the Plan; and
- (r) do such other acts as it deems reasonably required to administer the Plan in accordance with its provisions, or as may be provided for or required by law.

13.02 Fiduciary Duties. *The Book of Discipline* is the sole source of Wespath's fiduciary duties. *The Book of Discipline* provides that Wespath shall discharge its duties under the Plan:

- (a) for the primary purposes of providing benefits to Participants and their Dependents and beneficiaries, and defraying reasonable expenses of administering the Plan;
- (b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- (c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with the provisions of *The Book of Discipline*.

The foregoing is a Church law standard and not intended to incorporate or memorialize any secular law standard. Wespath will have been deemed to have satisfied these fiduciary duties if it takes action authorized by Section 14.07 (Use of Surplus).

13.03 Allocation or Delegation of Duties and Responsibilities. In furtherance of its duties and responsibilities under the Plan, Wespath may (subject always to the requirements of Section 13.02):

- (a) employ agents including, but not limited to, Claim Administrators, to carry out non-fiduciary responsibilities;
- (b) employ agents including, but not limited to, Claim Administrators, to carry out fiduciary responsibilities; and
- (c) consult with counsel who may be of counsel to Wespath.

13.04 Records and Reports. The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, records and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to appropriate government entities, Participants and others as required by law.

13.05 Duties of the Plan Sponsor. The Plan Sponsor shall assume the following duties with respect to the Plan:

- (a) to determine initial eligibility consistent with the terms of the Plan and to enroll Clergy Employees and Lay Employees, as applicable, within 31 days of each Employee satisfying the eligibility requirements of the Plan;
- (b) to maintain records of Participants' Compensation, enrollment and elections;
- (c) to remit Required Contributions to the Plan Administrator;
- (d) to provide the Plan Administrator with Notice of a Participant's Termination of Employment, Termination of Conference Relationship or Change of Status, where the Plan Sponsor is made aware of such Change of Status;
- (e) to provide the Plan Administrator with statistical data and other information satisfactory in form and accuracy to the Plan Administrator within a reasonable time after a request by the Plan Administrator and in a manner sufficient to enable the Plan Administrator to discharge its duties under the Plan;
- (f) to register with and report to government agencies, as appropriate;
- (g) to comply with applicable federal and state laws and regulations including, but not limited to, nondiscrimination requirements;
- (h) to properly notify Clergy Employees and Lay Employees of their rights and obligations under the Plan, including giving Notices required under the Plan, HIPAA, PPACA or the Code;
- (i) to comply with the terms of HIPAA including, but not limited to, the Privacy Rule and the Security Rule; and

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- (j) to execute an Adoption Agreement indicating any elections regarding optional Plan provisions and any other information called for by the Adoption Agreement.

The Plan Sponsor may be deemed to satisfy its duties through actions by a Salary-Paying Unit or other entity, but the Plan Sponsor remains responsible for the duties if they are not carried out in a timely fashion.

13.06 Claims and Appeals Procedure. The following claims and appeals procedures are subject to any additional rules or procedures that the Plan Administrator may adopt from time to time that are not inconsistent herewith:

- (a) ***Filing of a Claim.*** A Claim for benefits under the Plan must be filed by a Claimant with the Plan Administrator or a Claim Administrator in a format determined by the Plan Administrator or Claim Administrator within one (1) year after the later of the date:
 - (i) the events giving rise to the Claim occurred, or
 - (ii) the Claimant knew or should have known of the facts or events giving rise to the Claim.

If such claim is not filed within one (1) year as described in Section 13.06(a), the Claimant will be deemed to have waived his or her right to make a Claim or to pursue any other remedy, including filing a lawsuit. Generally, a Notice of the disposition of a Claim will be sent to the Claimant within 45 days after all required Forms and materials related to the Claim have been filed. If special circumstances require an extension of time, a Notice of the extension will be furnished to the Claimant, and a Notice of the disposition of a Claim will be sent within an additional 90 days. In compliance with the PPACA and PHSA, Claimants will be notified of a benefit determination (whether adverse or not) with respect to a Claim involving urgent care as soon as possible, taking into account medical exigencies, but not later than 24 hours after the receipt of the Claim. All Claims and appeals procedures established by the Plan Administrator, its Claim Administrators, Insurers and other agents, will comply with applicable provisions of the PPACA, PHSA, and regulations thereunder to the extent required.

- (b) ***Denial of Claim.*** If any Claim for benefits under the Plan is wholly or partially denied, the Plan Administrator or Claim Administrator will send the Claimant a Notice of the denial written in a manner calculated to be understood by the Claimant, generally setting forth the following information:
 - (i) the specific reasons for such denial;
 - (ii) specific reference to pertinent Plan provisions on which the denial is based;
 - (iii) description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary; and
 - (iv) explanation of the Plan's appeals procedures.

If a Claimant is denied benefits or eligibility hereunder, the Claimant shall have the right to appeal the decision in accordance with the following procedures:

- (c) ***Appeal Procedure.*** Wespath shall establish an appeal procedure that complies with applicable sections of the PPACA and PHSA governing appeals of adverse benefits determinations to the extent required.
- (i) This appeal procedure may differ for each of the types of Benefit Options offered hereunder.
 - (ii) The established appeal procedure shall be published in the description of each of the Benefit Options.
 - (iii) Wespath may delegate any established appeal procedure to a Claim Administrator, Insurer or other agent through agreement, contract or insurance policy.
- (d) ***Final Appeal Procedure.***
- (i) Notwithstanding anything in the Plan to the contrary, Wespath may delegate the final appeal procedure and determination, with respect to any Benefit Option under the Plan, through agreement, contract or insurance policy to a Claim Administrator, Insurer or other entity. In the event that Wespath so delegates the final appeal procedure to an agent, neither the Plan Administrator nor the Appeals Committee described in Section 13.06(d)(ii) shall hear or decide appeals related to the Benefit Option for which such final appeal procedure has been so delegated.

If Wespath delegates the final appeal procedure with respect to any Benefit Option under the Plan to a Claim Administrator, Insurer or other agent, Wespath shall publish the final appeal procedure in the description of such Benefit Option. The decision of the Claim Administrator or other agent to whom a final appeal procedure has been delegated, with respect to appeals that it is authorized to hear and decide, shall be final and not subject to action of Wespath. Wespath shall ensure that delegated appeals procedures comply with applicable provisions of the PPACA, PHSA and regulations thereunder regarding appeals or adverse benefits determinations.

- (ii) There shall be an Appeals Committee of Wespath elected by Wespath that shall hear and decide appeals of denials only of those Claims for which the Claim and appeal procedures have not been delegated to a Claim Administrator, Insurer, or other entity, and only after Wespath's established internal appeal procedure has been exhausted.
- (iii) The Appeals Committee's decision, with respect to appeals that it is authorized to hear and decide, shall be final and not subject to action of the Plan Administrator.
- (iv) After the initial appeal procedure has been completed, if the Claimant's Claim is still fully or partially denied [other than Claims subject to Section 13.06(d)(i)], the Claim may be heard by the Appeals Committee. The Claimant must submit the request for review by the Appeals Committee in writing on Forms supplied by the Appeals Committee. The Appeals Committee will review the Claim in accordance with its rules and procedures.

- (A) The Claimant, his or her duly authorized representative, or a representative of the Plan Sponsor, may request permission to appear personally or by teleconference or videoconference before the Appeals Committee to present evidence with respect to the Claim, subject to conditions and time limitations set by the Appeals Committee; however, the expense for any such personal appearance will not be borne by Wespath or the Plan.
 - (B) The Appeals Committee, or its agent, shall provide written Notice of the decision resulting from an appeal to the Claimant. Such Notice shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant, and such Notice shall be mailed to the Claimant by the Appeals Committee or its agent within a reasonable time following the action by the Appeals Committee.
- (e) **External Review.** Pursuant to and to the extent required by the PPACA and PHSA, after exhausting the applicable appeal procedure, a Claimant may choose to participate in an external review program (External Review). External Review applies only if the adverse benefit determination is based on clinical reasons or any exclusions for experimental or investigational services or unproven services. External Review is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits.
- (f) **Appeal a Condition Precedent to Civil Action.** No cause of action in civil law with respect to any alleged violation of the terms and conditions of this Plan or any contract hereunder shall be commenced or maintained by any Participant or other Claimant in state or federal court unless and until such Participant shall have initiated and completed the process of an Appeal as set forth in this Section 13.06. Any such cause of action with respect to this Plan must be commenced by the Claimant within twelve (12) months of the date of the written Notice sent by the Appeals Committee or its agent, or by the Claims Administrator, as applicable, to the Claimant regarding the final denial of the Appeal.

Article XIV – Adoption, Amendment and Termination

14.01 Adoption of Plan. This Plan may be adopted by any Plan Sponsor described in Section 1.06 with the consent of the Plan Administrator.

14.02 Adoption Agreement. Any Plan Sponsor adopting this Plan shall file with the Plan Administrator an Adoption Agreement. The Adoption Agreement for the Plan will be in a form prescribed by the Plan Administrator. An adopting Plan Sponsor must complete an Adoption Agreement which, once completed, must be acceptable to the Plan Administrator. The effective date of the Adoption Agreement cannot be any earlier than the first day of the current Plan Year unless the Plan Administrator approves an earlier date after considering any relevant circumstances.

14.03 Plan Sponsor Termination. A Plan Sponsor's sponsorship of the Plan may be terminated as follows:

- (a) Upon written notice to the Plan Administrator 180 days in advance of the date of such termination, a Plan Sponsor may terminate its sponsorship of the Plan as established with the Plan Administrator. In such a case, unless all Plan Sponsors terminate sponsorship of the Plan, the Plan will continue in operation as to all non-terminating Plan Sponsors. As a condition precedent to its right to terminate sponsorship of the Plan, a Plan Sponsor must provide written notice of its intent to its Participants at least 60 days in advance of the proposed date of such termination and must provide to the Plan Administrator evidence of such written notice to the affected Participants. In its discretion, Wespath may waive the required 180 days' notice that a Plan Sponsor ordinarily must provide in order to terminate sponsorship of the Plan and may allow the termination to become effective as soon as administratively practicable. Wespath may only waive such notice in circumstances that it reasonably determines would cause significant hardship to the Plan Sponsor if termination were delayed, and such immediate termination would not prejudice the Plan (e.g., financially, contractually, actuarially or otherwise), its remaining Plan Sponsors or Participants. The Plan Sponsor's indemnification obligations under Section 15.17 of the Plan shall survive such termination.
- (b) Upon written notice to a Plan Sponsor at least 90 days in advance of the date of such termination, the Plan Administrator may terminate a Plan Sponsor's sponsorship of the Plan for breach of the Plan's provisions. The Plan may terminate a Plan Sponsor's sponsorship of the Plan for late remittance or non-remittance of Required Contributions to the Plan Administrator. The Plan Administrator shall notify the Plan Sponsor as provided in the Premium Collection Policy established by the Plan Administrator under Section 3.06(f). Plan Sponsor will not be eligible to re-adopt the Plan through an Adoption Agreement for a period of three (3) years after such termination. The termination of a Plan Sponsor from sponsorship under this Plan will not excuse the Plan Sponsor from making payment in full for all Required Contributions for any period of sponsorship of the Plan.

14.04 Amendment of Plan. Wespath may amend prospectively or retroactively any or all provisions of this Plan or the Adoption Agreement at any time by written instrument identified as an

amendment of the Plan, effective as of a specified date. The Plan Administrator may amend prospectively or retroactively any and all administrative and non-substantive provisions of an Adoption Agreement.

- (a) Subject to the discretion of the Plan Administrator, a Plan Sponsor may amend any elective provisions of its Adoption Agreement at any time, with an effective date no earlier than the effective date of the applicable Adoption Agreement, to any extent that it may deem advisable without the consent of any Participant. However, no such amendment may be retroactive without the consent of the Plan Administrator.
- (b) No amendment may, without written consent of the Plan Administrator or Trustee, deprive the Plan Administrator or Trustee, respectively, of any of its exemptions and immunities; nor may such amendment change the duties, responsibilities, rights or privileges of the Plan Administrator or Trustee or the provisions of any contract. If any amendment by the Plan Sponsor affects the rights, duties, responsibilities or obligations of the Plan Administrator or Trustee hereunder, such amendment may be made only with the consent of the Plan Administrator or Trustee.
- (c) If the Plan (including the Adoption Agreement) is amended in a manner deemed materially unacceptable to a Plan Sponsor, that Plan Sponsor may terminate its participation in the Plan in accordance with Section 14.03. If the Plan Sponsor gives Notice of such termination within 30 days after it learns of a Plan amendment that it deems materially unacceptable, then either:
 - (i) the Plan Administrator may withdraw or revise such amendment or re-amend the Plan so that the unacceptable elements of such amendment will not become effective as to such Plan Sponsor, or
 - (ii) the Plan Sponsor's participation in the Plan may terminate pursuant to Section 14.03.

However, Wespath is authorized to amend any or all provisions of this Plan at any time by such written instrument in order to ensure the Plan complies with any applicable law or regulation. However, the Plan Sponsor shall not have a right to terminate its participation in the Plan on account of such regulatory amendments.

14.05 Termination of Plan by Wespath. Wespath has the right to terminate the Plan and the Trust at any time by giving 90 days advance written notice to all Plan Sponsors. The disposition of assets remaining in the Plan, if any, after all obligations of the Plan have been satisfied, will be at the discretion of Wespath.

14.06 Preservation of Rights. Termination or amendment of the Plan shall not affect the rights of any Active Employee in his or her Health Care FSA or Dependent Care FSA to the extent that he or she can claim reimbursement for expenses incurred prior to such termination or amendment as the case may be to the extent such amount is payable under the terms of the Plan prior to the effective date of such termination or amendment.

14.07 Use of Surplus. To the extent that Wespeth determines that HealthFlex has accumulated a surplus of funds beyond what is needed to pay incurred but not reported claims and has met additional required surplus thresholds, their disposition shall be at the discretion of Wespeth, including but not limited to additions to existing reserves, distributions to Plan Sponsors, or loans or contributions to other funds for the purpose of providing for, aiding in, and contributing to the support, relief, assistance, pension, welfare, or other benefits of denominational clergy, lay workers of the various units of the Church, or their families.

Article XV – Miscellaneous

15.01 Facility of Payment. If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of being a minor, illness or infirmity, mental incompetency, or incapacity of any kind, the Plan Administrator may, in its discretion, take the following actions:

- (a) apply such amount directly for the comfort, support and maintenance of such person; and
- (b) pay such amount to a legal representative or guardian or any other person selected by the Plan Administrator to disburse the amount for such comfort, support and maintenance, including without limitation any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution in whose care or custody the person entitled to the amount may be. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his or her credit in any savings or commercial bank of the Plan Administrator's choice.

Any payment by the Plan Administrator in accordance with this Facility of Payment section will discharge the Plan Administrator from all further liability to the extent of the payment made.

15.02 Lost Payee. Any amount due and payable to a Participant shall be forfeited if the Plan Administrator after reasonable effort is unable to locate the Participant to whom payment is due. Such forfeited amounts shall become part of the assets of the Plan. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

15.03 Funding. The obligations of the Plan Sponsors and Salary-Paying Units under this Plan may be funded through contributions to a trust, but need not be, except to the extent required by law. Nothing contained in the Plan shall give a Participant any right, title or interest in any property of the Plan Sponsors and Salary-Paying Units.

15.04 Titles and Headings. The titles and headings of the Articles and Sections of this instrument are placed herein for convenience of reference only, and in the case of any conflicts, the text of this instrument rather than the titles or headings, shall control.

15.05 Number. Wherever used herein, the singular shall include the plural and the plural shall include the singular, except where the context requires otherwise.

15.06 Applicable Law. The Plan and each of its provisions shall be construed according to, and its and their validity determined by, the laws of the State of Illinois, other than its laws respecting choice of law, to the extent such laws are not pre-empted by any federal law, and in accordance with applicable federal law, and to the extent that *The Book of Discipline* is not the applicable governing law. The Plan is intended to be:

- (a) a cafeteria plan under Code §125(d) containing a medical expense reimbursement plan under Code §105 and a dependent care expense reimbursement plan under Code §129;

- (b) an employee welfare benefit plan under ERISA §3(1); and
- (c) a Church Plan under Code §414(e) and ERISA §3(33) exempt from Title I of ERISA by ERISA §4(b)(2) and shall be construed accordingly.

In addition, state insurance laws and regulations shall not apply to the Plan to the extent they:

- (d) are pre-empted by federal law, including, but not limited to, ERISA, the Code, HIPAA, the Church Plan Parity and Entanglement Prevention Act of 1999 (Public Law No: 106-244), and *State ex rel. Farmer v. Monsanto Company*, 517 S.W.2d 129 (Mo. 1974); and
- (e) are made inapplicable by state laws, regulations, or case law that exempt self-insured Church Plans from the applicability of state insurance statutes and regulations.

15.07 Conformance with Applicable Law. Wespath may alter any Benefit Option or any portion thereof including, but not limited to, lifetime benefit maximums, deductibles, exclusions and benefits that are offered under a particular Benefit Option, in order to conform with the laws and regulations thereto of a particular jurisdiction in which this Plan will operate. In addition, Wespath may alter any Benefit Option or Plan provision, or interpret such to conform and comply with the PPACA, PHSA, and any regulations, temporary, proposed, interim final or final, and sub-regulatory guidance issued under these laws by the U.S. Department of Health and Human Services, the Internal Revenue Service, the U.S. Department of Labor and, where applicable, rules and regulations related to these laws issued by the Illinois Department of Insurance or another state agency with appropriate jurisdiction. In addition, unless the context clearly indicates to the contrary, a reference to a Plan provision, statute, regulation, or document shall be construed as referring to any subsequently enacted, adopted, or executed counterpart.

15.08 Continuation of Benefits Not Guaranteed. Nothing contained in this Plan, nor in the descriptions of the Benefit Options offered hereunder, shall be construed to guarantee the continuation of benefits beyond the current Period of Coverage in which a Participant is participating.

15.09 Pooling of Assets and Claims. Wespath, at its own discretion, may pool the assets and claims of this Plan with the assets and claims of other benefit plans administered by Wespath in accordance with rules, regulations, and policies adopted by Wespath.

15.10 Assignment. Employees and Dependents covered under this Plan may not assign, alienate, anticipate or commute any payments under this Plan (except as specifically provided in this section). Further, except as prescribed by law, payments under this Plan will not be subject to the debts, contracts or engagements of any person, nor to any judicial process to levy upon or attach the same for payment. Participants may, however, with the Plan Administrator's approval, authorize the payment of benefits under this Plan directly to the person or institution on whose charges the Claim is based. The Plan and Plan Administrator will be discharged from all liability to the extent of any such payment.

- 15.11 Overpayments.** If an overpayment has been made under the Plan, the Plan Administrator will have the right to recoup and recover any such overpayment from the person to whom such overpayment was made or from any person who received such overpayment through whatever means are necessary, including, without limitation, deduction of the overpayment amount from future claims and/or legal action.
- 15.12 No Guarantee of Employment.** Neither the creation of the Plan nor anything contained in the Plan gives any Employee any right to remain in the employ of the Plan Administrator or any Plan Sponsor; or any equity or other interest in the assets, business or affairs of the Plan Administrator or any Plan Sponsor.
- 15.13 Waiver of Claims.** Neither the creation of the Plan nor any modification of the Plan nor the payment of any benefits under the Plan will give any Employee or any other person any legal or equitable right against the Plan Administrator, any Plan Sponsor or any service agent (or any employee of the Plan Administrator, any Plan Sponsor or of any service agent) unless such right is specifically provided for in the Plan.
- 15.14 Severability.** If any provision of this Plan is held to be illegal for any reason, that illegality or invalidity will not affect the remaining provisions of this Plan. In such case, this Plan will be construed and enforced as if the illegal or invalid provision or section were not included in the Plan.
- 15.15 Workers' Compensation Unaffected.** This Plan is not in lieu of and does not affect any requirements for coverage under workers' compensation laws of any state.
- 15.16 Limitation of Liability.** All benefits hereunder are contingent upon and payable solely from the assets of the Trust, including insurance purchased from the Trust, which derive from such Contributions as are received by the Trustee and the investment results attained by the Trustee. No financial obligations, other than those that can be met by the Contributions actually received and the investment results (reduced by any of the Plan Administrator's and Trustee's administrative expenses and charges against the Trust's assets) will be assumed by the Plan Administrator or the Trustee. The Plan Administrator, Claim Administrator, Recordkeeper, Trustee, their officers, employees, contractors or agents will not be personally responsible or otherwise liable for the payment of any benefits hereunder. To the extent permitted by law, Wespeth shall not incur any liability for any acts or failure to act except for its own willful misconduct.
- 15.17 Indemnification.** The Plan Sponsor agrees to indemnify the Plan Administrator against any and all actions, causes of action, claims, demands, damages, and liabilities incurred or occasioned by any act or omission of the Plan Administrator undertaken in good faith in administration of the Plan. Each Participant agrees to indemnify the Plan Sponsor and the Plan Administrator against and reimburse the Plan Sponsor and Plan Administrator for any benefit paid or provided erroneously to or on behalf of such Participant or his or her Spouse or Dependents. Each Participant agrees to indemnify the Plan Administrator against any and all actions, causes of action, claims, demands, damages, and liabilities incurred or occasioned by any act or omission of the Plan Administrator undertaken in good faith in administration of the Plan.

15.18 Alternative Dispute Resolution. If a dispute arises out of or related to the relationship between any Plan Sponsor and the Plan Administrator or Trustee that is not resolved by the parties themselves, the parties agree first to try in good faith to settle the dispute by mediation through the American Arbitration Association, or another mediation or arbitration service mutually agreed upon by the parties, before resorting to arbitration. Thereafter, any remaining unresolved controversy or claim arising out of or relating to the relationship between the Plan Sponsor and the Plan Administrator or Trustee will be settled by binding arbitration through the American Arbitration Association, or the other mediation or arbitration service mutually agreed upon by the parties.

- (a) The site of the mediation or arbitration will be in a city mutually agreed upon by the parties.
- (b) The laws of the State of Illinois will apply in situations where federal law is not applicable. The applicable rules of the selected arbitration service will apply. If the service allows the parties to choose the number of arbitrators, unless another number is mutually agreed to, any arbitration hereunder will be before three arbitrators. The award of the arbitrators, or a majority of them, will be final. Judgment upon the award rendered may be entered in any court, state or federal, having jurisdiction.
- (c) The fees and costs for mediation will be borne equally by the parties. The fees and costs of arbitration will be allocated to the parties by the arbitrators.

15.19 Participant and Beneficiary Duties. Each person entitled to benefits under the Plan must file with the Plan Administrator and Plan Sponsor from time to time such person's post office address and each change of post office address. Failure to do so may result in the forfeiture of benefits otherwise due under the Plan.

15.20 Adequacy of Evidence. Evidence that is required of anyone under the Plan must be executed or presented by proper individuals or parties and may be in the form of certificates, affidavits, documents or other information that the person acting on such evidence considers pertinent and reliable.


15.21 Notice to Other Parties. A notice mailed first class, postage prepaid, to a Participant at his or her last address filed with the Plan Administrator will be binding on the Participant for all purposes of the Plan and will be deemed given on the date indicated on the notice or letter. A Claim for benefits, an election or other Notice mailed first class, postage prepaid, from a Participant to the Plan Administrator will be deemed given on the date of the postmark. Any party may also give a Notice as otherwise permitted under the Plan, and the Plan Administrator may establish rules relating to Notices, including when and how they may be given. Notices may be addressed to the Plan Administrator at the following address (or such other address as the Plan Administrator may designate from time to time):

HealthFlex Plan Document

Wespath Benefits and Investments
Plan Administrator of the HealthFlex Plan
1901 Chestnut Avenue
Glenview, IL 60025

- 15.22 Waiver of Notice.** Any notice under the Plan (including any Notice) may be waived by the person entitled to such notice. Acknowledgement of receipt of a notice will be deemed a waiver of any failures relating to the Plan-required means of giving such notice (but will not necessarily be deemed a waiver of the timeliness of such notice). Waiver of notice in one instance, however, will not be deemed to be a waiver in a later instance.
- 15.23 Successors.** This Plan is binding on the Plan Sponsors, and on all persons entitled to benefits hereunder, and their respective successors, heirs and legal representatives.
- 15.24 Rules and Forms.** The Plan Administrator will have the authority and responsibility to:
- (a) adopt rules, regulations and policies for the administration of this Plan, in all matters not specifically covered by this Plan Document; and
 - (b) prescribe such Forms and records as are needed for the administration of the Plan.
- 15.25 No Vested Interest.** Except for the right to receive any benefit payable under the Plan in regard to a previously incurred claim, no person shall have any right or interest in or to the assets of the Plan, Plan Administrator, or any Plan Sponsor.
- 15.26 Fraud and Abuse.** Any individual who knowingly and willfully executes, or attempts to execute, a scheme to defraud the Plan, or to obtain by means of false or fraudulent statements any Plan assets, may be immediately terminated from participation under the Plan. Such termination may be retroactively effective to the extent permitted by law. In addition, the Plan Administrator has the right to seek full recovery of any losses from, and to pursue criminal and civil prosecution against, such individuals.

IN WITNESS WHEREOF, pursuant to the authority delegated to Wespath staff by resolutions of the Board of Directors thereof adopted on February 26, 2021 and July 16, 2021, the foregoing HealthFlex Plan is hereby amended and restated on December 16, 2025, with effect as of January 1, 2026.

By: 
Martin Bauer
Senior Managing Director, Benefit Plans
Wespath

Appendix A

Benefit Options as of January 1, 2026

The following are the Benefit Options offered under the Plan as of January 1, 2026 and the corresponding Coverage Document(s) that governs the terms of the Benefit Option to the extent that those terms do not conflict with this Plan document. The Plan Administrator may update this list from time to time without formal amendment to the Plan.

Benefit Option	Claims and/or Third-Party Administrator(s)	Coverage Document(s)	Part of Cafeteria Plan	Part of HIPAA Covered Entity
Health Care Benefits (i.e., Medical, Mental Health, and Pharmacy), including: 1. PPO B1000 2. C2000 with HRA 3. C3000 with HRA 4. H2000 with HSA 5. H2500 with HSA 6. H5000 with HSA	Medical and Mental Health - Blue Cross Blue Shield of Illinois or UnitedHealthcare Pharmacy - OptumRx	HealthFlex Benefits Booklet	Yes	Yes
Vision Benefits*, including: 1. Vision Exam Core 2. Vision Full Service 3. Vision Premier	VSP		Yes	Yes
Dental Benefits, including: 1. Dental PPO 2. Dental Passive PPO 2000 3. Dental HMO*	Cigna		Yes	Yes
Health Care FSA	HealthEquity		Yes	Yes
Dependent Care FSA	HealthEquity		Yes	No
Health Reimbursement Account	HealthEquity		No	Yes
Health Savings Account	HealthEquity		Yes	No
Employee Assistance Program	Optum Health	The Plan Administrator provides Participants with various communications regarding the components of these programs.	No	Yes
Well-Being Program	Personify Health, Quest Diagnostics, Omada, Weight Watchers		No	Yes

* These benefits are fully insured. All benefits without an asterisk are self-insured.