ASEA/AFSCME Local 52

Health Care Reimbursement Account Plan

Amended and Restated
Effective January 1, 2021

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ASEA/AFSCME Local 52
Health Care Reimbursement Account Plan

PREAMBLE

The Plan shall be entitled the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan (herein "Health Care Reimbursement Account Plan" or "Plan"), originally adopted by the Board of Trustees for the ASEA/AFSCME Local 52 Health Benefits Trust effective July 1, 2001, and is hereby amended and restated effective January 1, 2021.

ARTICLE I
INTRODUCTION

1. Establishment of Plan

ASEA/AFSCME Local 52 and the State of Alaska, through collective bargaining, established the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan (Plan) effective July 1, 2001. The Plan is part of the total benefits package provided to members of the bargaining units and staffs of ASEA/AFSCME Local 52 and PSEA Local 803 through the ASEA/AFSCME Local 52 Health Benefits Trust.

2. Legal Status

This Plan is also intended to qualify as a "self-insured medical reimbursement plan" under section 105(h) of the Code. Further, the reimbursements of Qualifying Medical Care Expenses under this Plan are intended to be eligible for exclusion from participating Employees' gross income under section 105(b) of the Code.

3. Named Fiduciaries

The Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust Fund are the named fiduciaries of this Plan.

ARTICLE II
DEFINITIONS

"Administrative Agent" means the Third-Party Administrator for the ASEA/AFSCME Local 52 Health Benefits Trust and Plan(s), who is authorized by the Board of Trustees pursuant to a service agreement to perform the day-to-day administrative and business functions of the Trust.

"Benefits Booklet" means the current ASEA/AFSCME Local 52 Health Benefits Plan Booklet (which meets the requirements for a summary plan description). The Benefit Booklet describes in detail the separate Plan options available for election by Participants and the rules and conditions for the provision of benefits provided under the Plan. The Benefits Booklet is incorporated by reference into this Plan Document.

"Board of Trustees" means the Board of Trustees of the ASEA/AFSCME Local 52 Trust Fund.

"Change in Status" means any of the events described in Article IV, Section 4, as well as any other events included under subsequent changes to Code § 125 or regulations issued under Code § 125.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act.

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

"Collective Bargaining Agreement" means the collective bargaining agreement negotiated between an Employer and a labor organization representing the Employer's Employees' providing for participation in the Trust and governing the Contribution requirements (Employer and Employee) that fund some or all of the Benefits provided by this Plan.

"Compensation" means the total W-2 compensation for Federal income tax withholding purposes paid by the Employer to an Employee for services performed, determined prior to any Salary Reduction election under this Plan, prior to any salary reduction election under any other Code section 125 cafeteria plan, and prior to any elective salary deferral contributions under any Code section 401(k), 403(b) or 408(k) arrangement

"Deadline for Submission of Claims" means August 15 of the Plan Year following the Plan Year to which the Election applies.

"Dependent" means the Spouse (including persons legally separated, but not divorced) of the Employee or a child of the Employee who is—

(a) The Employee's natural child, adopted child or child placed for adoption, legally placed foster child, or child for whom the Employee is the legal guardian, who meets one of the foregoing categories, up to the attainment of age 26.

(b) A mentally or physically handicapped child who reaches age 19, while covered under the Plan, may continue coverage beyond their 26th birthday, if the child is:

- Chiefly dependent upon the Employee for support;

- Living with the Employee or in an institution;
- Not capable of self-sustaining employment; and
- Claimed as a dependent on the Employee's Federal income tax return for the Plan Year.

Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, as defined by the Public Health Service Act.

"Effective Date" of this Plan means July 1, 2001.

"Eligible Employee" means an Employee eligible to participate in this Plan as provided in Article III, Section 1.

"Employee" means—

(a) an individual the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll and covered by a collective bargaining agreement executed between the Employer and the labor organization representing the Employee, or through a Special Agreement, requiring contribution payments to the Plan,

(b) an Employee who is on leave without pay or who is a layoff Employee, or

(c) an Employee of an Employer participating in the Trust through a Special Participation Agreement.

"Employee Information Form" means the form supplied to the Employee by the Employer or the Administrative Agent, to be completed, signed, and returned by the Employee listing their personal identifying information and work classification data.

"Employer" means the State of Alaska or other such Employer who is entitled to participate in the benefit plans provided through this Trust, pursuant to collective bargaining and/or a Special Agreement approved by the Board of Trustees.

"Enrollment Form" means the form provided by the Administrative Agent for the purpose of an Employee's enrollment in the Plan, during any Open Enrollment Period, or within the required enrollment timeframe for an employee who is newly hired, changing from a non-benefit eligible position to a benefit eligible position, or experiences a Change in Status, in order to participate in this Plan by electing benefits in the form of reimbursements for Qualifying Medical Care Expenses, and to pay for such benefits with Salary Reductions.

"Enrollment Guide" means the ASEA/AFSCME Local 52 Health Benefits Plan Enrollment Guide for the applicable Plan Year.

"Family Information Form" means the form supplied to the Employee by the Administrative Agent to be completed, signed, and returned listing any eligible Dependents and providing proof of dependent status.

"Group Health Plan(s)" means the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan, the ASEA/AFSCME Local 52 Health Benefits Plan, and the benefit options offered thereunder.

"Layoff Employee" means an Employee who—

- has received notification of layoff by the Employer;
- is not currently working for the Employer;
- has a reserved position with the Employer; and
- is subject to recall for a maximum of two years from the date they cease work for the Employer.

A Layoff Employee is not considered to have separated from service with the Employer unless—

(a) they fail to return to work when recalled by the Employer; or

(b) two years expire from the date they cease work for the Employer due to layoff.

"Medical Reimbursement Account" or **"Account"** means the account described in Article V of this Plan.

"Named Fiduciary" means the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust.

"Open Enrollment" means the period specified by the Plan Administrator for annual election of benefits under the Plan.

"Participant" means an eligible Employee who becomes a Participant pursuant to Article III and/or eligible Dependents of the Employee.

"Plan" means the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan as set forth herein and as amended from time to time.

"Plan Administrator" means the Board of Trustees for the ASEA/AFSCME Local 52 Health Benefits Trust Fund.

"Plan Year" means the twelve-month period commencing July 1 and ending June 30.

"Qualified Reservist" means a Participant who is a reservist called to active duty for a period of at least 180 days or for an indefinite period.

"Qualifying Medical Care Expense" means an expense incurred by a Participant, or by the Spouse or Dependent of such Participant, for medical care as defined in Section 213 of the Code (including, without limitation, amounts for hospital bills, doctor, dental and vision bills and prescription drugs), but only to the extent that such Participant, Spouse, or Dependent incurring

the expense is not reimbursed through the Group Health Plan, or other insurance or another accident or health plan.

A medical expense is incurred at the time the medical care or service that gave rise to the expense is furnished.

A Qualifying Medical Care Expense shall not include an expense incurred for cosmetic surgery or other similar procedure, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent the threat of illness or disease.

A Qualifying Medical Care Expense shall not include—

(a) expenses for qualified long-term care services (as defined in Code section 7702B(c)); or

(b) expenses incurred for the payment of contributions or premiums under this Plan or any other group or individual health plan.

"Rollover Funds" means an amount not to exceed the maximum rollover amount, which is carried over to the subsequent Plan Year from which a Participant can obtain reimbursement of Qualifying Medical Care Expenses incurred during the period subsequent to the Plan Year in which the Participant elected to contribute to the Plan. The maximum rollover amount will adjust to the maximum limitation set annually by federal law.

"Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant properly completes and returns an Enrollment Form electing among Plans A, B, C or D, offered under the underlying Group Health Benefit Plan and/or Component Benefit Plan(s) with Pre-tax Contributions, during an Open Enrollment period, upon being newly hired, or due to a Change in Status election change.

"Special Agreement" means an agreement whereby the Board of Trustees approves participation in the benefit plans offered through the Trust by Employees of an Employer that is not subject to a collective bargaining agreement with ASEA/AFSCME Local 52 or PSEA Local 803.

"Spouse" means an individual who is legally married to an Employee and who is treated as a Spouse under the Code (may be separated but not divorced).

"Terminated Employee" means an Employee who has separated from employment with the Employer, who is not on Layoff status or leave without pay.

"Trust Fund" or **"Trust"** means the ASEA/AFSCME Local 52 Health Benefits Trust Fund.

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

ARTICLE III
PARTICIPATION

1. Eligibility to Participate

Benefits are provided under this Plan to Employees (and their Dependents) covered under a Collective Bargaining Agreement requiring participation in and contributions to the Trust, or Employees of Employers participating in the Plan pursuant to a Special Agreement, as described below:

(a) Full-time Employees (scheduled to work 30 or more hours a week on a regular basis);

(b) Full-time seasonal Employees; or

(c) Part-time Employees who elect to participate in the Plan (scheduled to work at least 15 but less than 30 hours a week on a regular basis). A part-time Employee must elect coverage within 30 days of the date of the cover letter sent by the Administrative Agent enclosing the New Hire packet to said Employee.

The Employer and Employee Contribution rate for the underlying Group Health Benefit Plan coverage under Plans A, B, C, and D, will be set by the Collective Bargaining Agreement in force at the time of coverage. The Employee Salary Reduction for the election under this Plan must be designated by the Employee upon enrollment or, if an Employee fails to make a timely election, the Employee Salary Reduction shall be the rate for coverage under Plan A. Participation pursuant to a Special Agreement may provide for separate eligibility rules, such as hours of employment or probationary status.

Employees must be actively at work and receiving Compensation from the Employer for their performance of their duties, or otherwise eligible to participate under the provisions of the underlying Collective Bargaining Agreement in force for the Plan Year.

Employees must complete, sign, and return the Enrollment, Employee Information, and Family Information Forms, along with proof of Dependent(s) status, before benefits will be paid on eligible Dependents.

2. Election to Participate

(a) ***Active Enrollment into Group Health Plan A. B, C or D Required:*** An Employee will only be entitled to elect coverage under the Plan in conjunction with an active enrollment in the ASEA/AFSCME Local 52 Health Benefits Plan options A, B, C, or D.

(b) ***Elections During Open Enrollment Period:*** During each Open Enrollment Period with respect to a Plan Year, the Administrative Agent shall provide (by mail or electronically) an Enrollment form to each Employee who is eligible to participate in this Plan. The Enrollment Form shall enable the Employee to participate in the various options of the underlying Group Health Benefits Plan and this Plan for the next Plan Year and to authorize the necessary Salary

Reductions to pay for the benefits elected. The Enrollment Form must be postmarked or received electronically (or date stamped by the Administrative Agent if delivered by means other than U.S. Mail or electronically) on or before the last day of the Open Enrollment Period. If an eligible Employee elects to participate during an Open Enrollment Period, they (and their eligible Dependents, when applicable) become a Participant on the first day of the applicable Plan Year. If an eligible full-time Employee fails to return the Enrollment Form or fails to complete the online enrollment within the required period, they will be defaulted into the Group Health Benefits Plan A until a new election is made during the next Open Enrollment Period, unless they experience a Change in Status event and make a new election pursuant to the Change in Status rules. Part-time employees who fail to make an election during Open Enrollment will not be permitted to participate in the Plan unless they experience a Change in Status event and make an appropriate election due to that event.

(c) ***Elections by Employees Hired During a Plan Year:*** An Employee who is hired by the Employer during a Plan Year must timely complete and return an Employee Information Form to the Administrative Agent. Upon receipt, the Employee will be sent a cover letter, "What you Need to Do" document, Benefit Guide, Enrollment Form, Family Information Form, and HCRA Savings Information Form, among other enrollment materials (by mail or electronically) by the Administrative Agent. The Employee will have 30 days from the date on the cover letter to return the Enrollment Form and the Family Information Form (if applicable) indicating their elected benefits and Salary Reduction (if applicable). If the Administrative Agent does not receive an Employee's completed Enrollment Form or online enrollment, postmarked or electronically filed (or date stamped by the Administrative Agent if delivered by means other than U.S. Mail or electronically) within 30 days from the date on the cover letter provided with the enrollment documents, the Employee will be defaulted into the Group Health Benefit Plan A. If the Employee is defaulted into Group Health Plan A they will not be eligible to participate in the Plan until a new election is made during the next Open Enrollment Period, or a Change in Status event occurs and they make a new election pursuant to the Change in Status rules. Part-time employees who fail to make an election as a new hire will not be permitted to participate in the Plan unless they experience a Change in Status event and make an appropriate election based on that event.

3. Commencement of Participation

(a) ***New Employees:*** A Participant shall become covered under the Plan on the first day of the month following 30 consecutive days in paid status, provided that Contributions have been remitted on the Employee's behalf. Employees must make an election within 30 days of the date of the cover letter accompanying the enrollment materials as described in Section 2(c) above, or the Employee will be automatically defaulted into Group Health Plan A, with no benefit under the Plan. A Participant who has leave without pay during the first 30 days of employment will be covered on the first day of the month following the Employee's return to work and upon completion of a total of 30 consecutive days of paid status.

(b) ***Deferred Coverage Available for Seasonal Employees*:** A seasonal Employee may elect to defer the effective date of coverage for one or two months, which will correspondingly result in coverage ending on the last day of the first or second month following the month in which the Employee begins seasonal leave without pay. The Employee must follow the procedures established by the Plan to defer coverage, including completion and timely submission of the deferral form.

(c) ***Rehired Employees:*** If a previously covered actively working Employee, under the Group Health Benefit Plan, is rehired within 7 calendar days of the date that Employee's coverage terminated, the coverage will begin on the first day of the period for which Contributions are reported to the Administrator on the Employee's behalf, provided the corresponding required Contributions are paid to the Trust. If the Employee is rehired more than 7 calendar days after the Employee's coverage terminated, the Employee will be considered a new Employee and coverage will begin as described in the preceding paragraph.

(d) ***Employees Returning From Leave Without Pay or Layoff:*** If a previously covered Employee returns to work from leave without pay or layoff, coverage will begin the first day that the corresponding required Contributions are paid to the Trust, (unless the Employee defers coverage as described in Paragraph (b) above, provided the Employee is not subject to the Active at Work provision described in Paragraph (i) below.

(e) ***Employees Moving from a Nonparticipating Unit:*** Employees who move from another bargaining unit shall be covered on the first day of the month after the bargaining unit change occurs. If the Employee is not in pay status on day the bargaining unit change occurs, the Employee will not be covered until the day they return to pay status and the Trust receives Contributions on their behalf. If the Employee or one of the Employee's Dependents is hospitalized on the date coverage changes, the new coverage will start when the Employee or Dependent is discharged.

(f) ***Employees Moving from Part-Time to Full-Time Status*:** An Employee who moves from part-time to full-time status will be covered on the first day of the month following the date of the status change. If the Employee elected coverage as a part-time employee, the Plan election will remain in effect, and the Employee will have 60 days from the date of the status change to change their Plan election. If the Employee did not elect coverage as a part-time employee, the Employee must make an election within 30 days of the date of the cover letter enclosing the Enrollment Guide and Election Form. Failure to make an election will result in default into Group Health Plan A with no Health Care Reimbursement Account Plan benefits.

(g) ***Employees in Short-term Nonpermanent Appointments Extended Beyond 120 days:*** An Employee who moves from non-benefit-eligible status (such as short-term permanent or long-term nonpermanent) to benefit-eligible status (such as permanent or long-term nonpermanent) will be covered on the first day of the month following the date of the status change. The Employee must make a Plan election within 30 days of the date on the cover letter enclosing the Enrollment

Form and Family Information Form as described in Section 2(c) above, or the Employee will be defaulted into the Group Health Plan option A, with no Health Care Reimbursement Account Plan benefits. In no event may an Employee elect retroactive or prior Plan Year coverage under the Plan.

(h) ***Dependent Coverage:*** Dependent coverage begins on the same date as the Employee coverage for each of the categories listed above.

(i) ***Active at Work Provision:*** Any requirement regarding eligibility, or that an otherwise eligible person be actively at work before coverage may begin or remain in force is not applicable to health coverage, if the eligibility for coverage or the absence is due to a Health-Status-Related Factor. Moreover, the actively at work provision will not apply when eligibility is afforded through the terms of the collective bargaining agreement in effect for the Plan Year under the donated leave or catastrophic leave provisions, provided the full Employer and Employee Contributions are received by the Trust.

Health-Status-Related Factor means any of the following:

- Health status;
- Medical condition (including both physical and mental sickness);
- Claims experience;
- Receipt of health care;
- Medical history;
- Evidence of insurability (including conditions arising out of acts of domestic violence);
- Disability; or
- Genetic information.

4. Termination of Participation

Participation and/or coverage under the Plan will terminate as follows:

(a) ***Employees on Leave Without Pay or Layoff:*** Participation and coverage under the Plan terminates on the last day of the month in which the Employee was last in pay status or in which the Employee begins seasonal overtime conversion. If coverage ends while the Employee is on Family Medical Leave Act (FMLA) leave, coverage will be extended to the end of the month in which FMLA leave ends.

(b) ***Employees Who Terminate Employment:*** Participation and coverage ends on the last day of the month in which the Employee last worked.

(c) ***Employees Moving to a Nonparticipating Unit:*** Participation and coverage ends on the last day of the month in which the Employee moves out of the bargaining unit that entitled the Employee to participate in the Group Health Plan.

(d) ***Employees Moving from Full-Time to Part-Time Status:*** An Employee who moves from full-time status to part-time status will cease to be covered on the

last day of the month in which the status change occurred, unless the Employee elects to continue coverage as a part-time Employee within 30 days of the status change and makes a valid election to participate as a part-time Employee.

(e) ***Employees Moving from Benefit-Eligible Status to Non-Benefit Eligible Status:*** Coverage will end on the last day of the month in which the Employee is in benefit-eligible status.

(f) ***Failure to Pay the Required Premium:*** Participation and coverage terminates at the end of the month for which the last required contributions were paid (including COBRA and continuation coverage).

(g) ***Dependent Participation and Coverage:*** Coverage for a Dependent ends on the same day as the Employee's coverage ends, except in the case of—

- **Divorce:** coverage terminates for the Spouse on the date the divorce is final.

- **Dependent Child Ceases to Meet Eligibility Requirements:** coverage ends on the last day of the month in which the Dependent Child fails to meet any of the requirements for eligibility.

5. Participation Following Termination

After termination of participation under Article III, Section 4, an Employee's subsequent participation in this Plan shall not commence earlier than the first day of the next Plan Year. In such case, the rules set forth in Article III, Section 2(b) relating to elections during Open Enrollment Period, shall govern the timing and manner of making the subsequent election.

6. Special Rules for Employees on Layoff or Leave Without Pay, or Return from USERRA Leave

Layoff and leave-without-pay Employees, and Employees on USERRA leave will still be considered Employees of the Employer for purposes of Open Enrollment election of benefits and Change-in-Status election changes, and the notification thereof. These Employees are considered Participants who are ineligible to receive benefits under this Plan until they elect to participate under the terms of the Plan, and return to work for the Employer (return to work within two years of the date the Employee entered Layoff status for Layoff Employees, or return to work for leave-without-pay and USERRA-leave Employees).

Upon election to receive benefits under the terms of the Plan and recall by the Employer and return to work, the Layoff Employee's or leave-without-pay or USERRA-leave Employee's Salary Reduction and entitlement to reimbursement of Qualified Medical Care Expenses will take effect on the first day the Employee is recalled by the Employer or returns from such leave, and recommences work, provided that the Employee has sufficient earnings to make the required contribution. In situations where the Employee does not have sufficient earnings to make the required contribution, the Employee must self-pay the contribution to the Trust to remain eligible. If the Employee does not have sufficient earnings to make the required contribution, and the Employee does not pay the required contribution, the Employee will not be covered under the Health Care Reimbursement Plan until the Employee has sufficient earnings

and makes the required contribution retroactive to the date of their return to work. The Employee must be concurrently covered under the Group Health Benefit Component Plan in order to be covered by the Health Care Reimbursement Plan.

If the Employee returns from Layoff or leave without pay on a date of the month other than the first day of the month, the Employee will have deducted from their pay a pro rata amount of the required contribution for payment to the Trust. The pro rata amount will be determined by the calendar day of the month, including the day the Employee returns to work. The required monthly contribution will be determined as follows:

(a) Where the first day of return to work is on the 1st day of the month or from the 2nd through the 10th day of the month, the contribution due will be the full contribution.

(b) Where the first day of return to work is from the 11th through the 20th day of the month, the contribution due will be two-thirds (2/3) of the full month contribution.

(c) Where the first day of return to work is from the 21st through the 31st day of the month, the contribution due will be one-third (1/3) of the full month contribution.

In situations where the Employee's use of leave without pay may establish more than one return-to-work date during a calendar month, the earliest date in the month on which a return-to-work is established will control in determining the contribution owed.

Returning seasonal Layoff Employees may elect to defer the effective date of coverage for one or two months. Such deferral election is irrevocable once made. If the Employee elects to defer coverage, coverage will end on the last day of the month following the first or second month in which the Employee again begins seasonal leave without pay.

7. Pro Rata Coverage for Participants Commencing Coverage During a Plan Year

If an Employee commences coverage under this Plan during a Plan Year, due to a new hire by the Employer, a recall from layoff status, return from leave without pay, or return from Family Medical Leave Act (FMLA) Leave, such coverage will be prorated for the period remaining in such Plan Year. For example, an Employee who is hired by the Employer on October 31 and elects coverage with a Salary Reduction of $100.00 per month begins participation November 1. Such Employee is entitled to reimbursement of Qualified Medical Care Expenses totaling $800.00 for the remaining eight months of the Plan Year, reduced by prior reimbursements.

8. Qualifying Leave under Family and Medical Leave Act

Notwithstanding any provision to the contrary in this Plan, if an Employee goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, the Employer will continue to maintain the Employee's group health plan benefits on the same terms and conditions as if the Employee were still an active Employee. That is, if the Employee elects to continue their coverage while on leave, the Employer will continue to pay its share of the contributions to the Trust Fund to fund the coverage and the Employee must continue to pay their portion of the contributions for coverage with after-tax dollars, in a manner provided by the Administrative Agent. If an Employee does not elect to continue coverage during FMLA leave, or does not pay the required Employee share of the premium, then, upon

return to work after FMLA leave, coverage will be reinstated on the day of return to work on the same basis that it was in force prior to leave, subject to any changes that may have occurred in the Plan. Any partially satisfied waiting periods, including preexisting condition limitations, which were interrupted while on FMLA leave, will continue to be applied once coverage is reinstated. Other than the federal mandates of FMLA, the terms and conditions of entitlement to FMLA leave are defined by the Employer, not the Plan.

If the Employee elects to continue coverage while on leave, then the Employee will be permitted to pay their share of the premium for the Group Health Benefit Plan in one of the following ways, depending upon the elections in place at the time of the leave, and at the discretion of the Plan Administrator:

(a) With pretax salary reduction if the Employee's payroll is sufficient at the time of taking leave;

(b) with after-tax dollars, by sending monthly payments to the Administrative Agent; or

(c) under another arrangement agreed upon between the Employee and the Administrative Agent.

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

Under the FMLA, an Employee is entitled to continue their Group Health Plan coverage on the same basis as if they were an active-at-work employee, for up to 12 weeks during the 12 month period, as defined by the Employer, for any of the following reasons:

(a) to care for their child after the birth or placement of a child for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;

(b) to care for their spouse, child, foster child, adopted child, stepchild, or parent that has a serious health condition (as defined in by the FMLA); or

(c) to care for their own serious health condition (as defined by the FMLA).

The Employee must also (1) have worked for the Employer for at least one year (2) have worked at least 1,250 hours over the previous 12 months, and (3) continue to pay the Employee share of the contribution for coverage.

FMLA leave ends on the earliest of (1) the day the Employee returns to work; (2) the day the Employee notifies the Employer that they are not returning to work; (3) the day the Employee's coverage would otherwise have ended under the terms of the Plan; or (4) the last day of the 12 week FMLA leave period.

ARTICLE IV
BENEFITS AND ELECTIONS

1. Benefits

An election to participate in this Plan is an election to receive benefits in the form of reimbursements for Qualifying Medical Care Expenses, and to pay the premium for such benefits via Salary Reductions, up to the maximum amount elected under the Plan. The Benefit Guide and accompanying enrollment materials set forth and prescribe the manner and timing of the election of benefits under the Plan. Employees will have the option of electing between Group Health Plans A, B, C or D, and may also elect to participate in the Plan at Open Enrollment, upon new hire, or in the occurrence of a qualified change-in-status event or HIPAA Special Enrollment event. Health Care Spending Account Plan enrollments do not roll over from year to year. An Employee wishing to contribute to a Health Care Spending Account must actively enroll each year at Open Enrollment. However, an Employee who has rollover funds pursuant to Article V, Section 1(b) may continue to receive benefits for claims incurred in subsequent Plan Years, provided the claim is submitted by the Submission Deadline.

2. Maximum and Minimum Benefits

The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be the maximum set annually by federal law. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year shall be $240.00. Amounts received which are attributable to reimbursements due for Qualifying Medical Care Expenses incurred by the Participant's Spouse or Dependents will be considered to have been received by the Participant. For subsequent Plan Years, the maximum and minimum annual benefit amount may be changed by the Administrator and communicated to Employees via the Election Form or other document or notification.

3. Benefit Premiums; Salary Reduction Contributions

The annual premium for a Participant's benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $2,750.00 annual benefit amount is elected, the annual premium is $2,750.00). The Salary Reduction for each pay period for the Participant is an amount equal to the annual premium divided by the number of pay periods in the Plan Year.

4. Irrevocability of Election; Changes in Family Status

Except as provided in this Section, a Participant's election to participate in this Plan is irrevocable for the duration of the Plan Year to which it relates. That is, except as provided herein, for the duration of the Plan Year the Participant may not change—

(a) their participation in this Plan;

(b) the annual benefit amount they elected; or

(c) their Salary Reduction amount.

A Participant may modify their benefit election during a Plan Year effective as of the first day of the month following the receipt of the modification, if the modification is on account of and consistent with a Change in Status and is made no more than 60 days after the change occurs. A benefit election modification is consistent with a Change in Status only if the modification is necessary or appropriate as a result of the status change. A Participant who modifies their election may not make a new election for the remaining portion of the Plan Year, unless another Change in Status occurs and the Participant timely notifies the Administrator of such additional Change in Status. Upon termination of a Participant's election, their Salary Reductions will cease and they will not be able to receive reimbursement for Qualifying Medical Care Expenses incurred thereafter, but such Participant (or their estate) may claim reimbursement for any Qualifying Medical Care Expenses incurred on or before the date of their modification, up to the maximum benefit elected, provided they file a claim prior to the Deadline for Submission of Claims. If a Participant has Rollover Funds in their account, pursuant to Article V, Section 1(b) they may still receive reimbursements.

As set forth in Prop. Treas. Reg. Section 1.125.2, Q/A-6(c), examples of a Change in Status include—

(a) Marriage, divorce or legal separation of the Participant;

(b) Death of the Participant's Spouse or Dependent;

(c) Birth or adoption of a child of the Participant;

(d) Termination of employment (or commencement of employment) of the Participant's Spouse;

(e) Switching from part-time to full-time employment status or from full-time to part-time status by the Participant or their Spouse;

(f) Taking unpaid leave of absence by the Participant or their Spouse—such unpaid leave of absence does not include Layoff or suspension by the Employer; or

(g) Declaration of an Open Enrollment Period by the Plan Administrator.

ARTICLE V
REIMBURSEMENT PROCEDURE

1. Expenses That May Be Reimbursed

(a) **Claims Incurred During the Plan Year.** The Participant may receive reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year for which an Election is in force as defined by the Code and the regulations issued thereunder, or carried over, up to the maximum allowable rollover amount, as set annually by federal law, to the next Plan Year. Any funds remaining in the Account in excess of the maximum rollover amount will be forfeited.

(b) **Salary Reduction Account.** If, on the last day of the Plan Year for which an election was made, the Employee has salary reduction funds remaining in their Account, the remaining funds will be carried over, up to the allowable under federal law, to the next Plan Year. Any funds remaining in the Account in excess of the maximum allowable under federal law will be forfeited pursuant to Article V, Section 5(d). For purposes of the Rollover, a Plan Participant will remain enrolled in the Plan even if the Participant does not make a new election to participate through Salary Reduction for the following Plan Year(s). Rollover Funds may be used for qualifying expenses, provided the Employee continues to be covered under a Group Health Benefit Plan Election of Plan A, B, C, or D. Reimbursements from Rollover Funds will be paid for claims incurred during subsequent Plan Year(s) provided the claims are submitted by the Submission Deadline for the appropriate Plan Year in which the claim was incurred.

(c) **Qualified Reservist Distribution.** A Qualified Reservist may receive reimbursement of Qualifying Medical Care Expenses incurred during the period beginning with the call to active duty and ending on the last date reimbursements could otherwise be made for the plan year that includes the date of the call to active duty.

2. Maximum Reimbursement Available; Timing of Reimbursement

(a) **Maximum Reimbursement Available.** Reimbursement for Qualifying Medical Care Expenses of the maximum dollar amount elected by the Participant for a Plan Year (reduced by prior reimbursements during the Plan Year, and plus any Rollover Funds carried over pursuant to Article V, Section 1(b)) shall be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's Medical Reimbursement Account pursuant to Article V, Section 5. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Plan has terminated pursuant to Article III, Section 4, unless the Participant has elected COBRA as provided in Article V, Section 4.

(b) **Timing of Reimbursement.** As soon as practicable, and as directed by the Plan Administrator to the Administrative Agent, after the Participant submits a reimbursement claim to the Administrative Agent, the Plan will reimburse the

Participant for their Qualifying Medical Care Expenses (if the Administrative Agent approved the claim), or the Administrative Agent will notify the Participant that their claim has been denied.

3. Procedure for Claiming Reimbursement

A Participant who has elected to receive benefits for a Plan Year or carries over Rollover Funds may apply for reimbursement of Qualifying Medical Care Expenses incurred by the Participant or their Spouse or Dependents during the Plan Year by submitting an application in writing to the Administrative Agent in such form as the Plan Administrator shall prescribe, setting forth—

- the person(s) on whose behalf Qualifying Medical Care Expenses have been incurred;
- the nature of the expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such expenses have not otherwise been paid and are not expected to be paid through the Group Health Plan, or other health plan.

Such application shall be accompanied by bills, invoices, explanation of benefits (EOB) forms, or other statements from an independent third party showing the amounts of such expenses, together with any additional documentation which the Administrative Agent may request. A Participant may also obtain automatic reimbursement of Qualifying Medical Care Expenses, which represent the out-of-pocket portion of a claim submitted to the Plan, by checking the "authorization for automatic transfer from HCRA" box on their Open Enrollment Form or online enrollment. In order to be reimbursed under the Plan, application for reimbursement must be received by the Administrative Agent before the Deadline for Submission of Claims. An Employee may also authorize the Administrative Agent's Office to automatically submit the unpaid portion of their health claim to the Plan for payment from the Employee's Account by checking the appropriate election on their Open Enrollment Form or online enrollment.

Except for the final reimbursement claim for a Plan Year, no claim for reimbursement may be made unless and until the claim for reimbursement is at least $25.00. Reimbursements will not be made more often than twice per month per Participant.

4. Termination of Benefits

When a Participant ceases to be a Participant, their Salary Reductions will terminate, as will their election to receive reimbursements for Qualifying Medical Care Expenses. They will not be able to receive reimbursements for Qualifying Medical Care Expenses incurred after their participation terminates, but such Participant (or their estate) may claim reimbursement for any Qualifying Medical Care Expenses incurred between the beginning of the Plan Year and the date their participation terminated, provided they (or their estate) file a claim within 60 days following the close of the Plan Year in which the expense was incurred. If an Employee has Rollover Funds in their Account (up to the maximum set annually by federal law), the Employee will remain a Participant in the Plan, provided they are still covered under an Election in Plan A, B, C, or D of the Group Health Plan.

To the extent required by federal law (COBRA) (see, e.g., Code section 4980B), a Participant, and their Spouse and Dependents, whose coverage terminates under this Plan because of a COBRA qualifying event, shall be given the opportunity to continue coverage under this Plan on an after-tax basis for periods prescribed by COBRA and subject to all conditions and limitations under COBRA.

Individuals will be eligible for COBRA continuation coverage only if they have a positive Account balance at the time of their qualifying event. Moreover, the right to continue COBRA participation will terminate at the end of the Plan Year in which COBRA was elected or, in the case of Rollover Funds, until the Account is exhausted, and provided the Participant is still covered under the Group Health Plan under COBRA.

For rules relating to the entitlement to COBRA, COBRA election and the time period for which COBRA can be elected, refer to the Plan Booklet for the applicable Plan Year.

5. Establishment of Accounts

(a) **Medical Reimbursement Account.** The Administrative Agent will establish and maintain on its books a Medical Reimbursement Account for each Plan Year with respect to each Participant who has elected to participate in this Plan but will not create a separate fund or otherwise segregate assets for this purpose. The Account so established is solely for the purpose of determining forfeitures under subsection (d) below. As described in Article V, Section 2(a), the amount available for reimbursement of Qualifying Medical Care Expenses is the Participant's annual benefit amount, reduced by amounts reimbursed for the Plan Year, plus any Rollover Funds pursuant to Article V, Section 1(b). The amount available is not based on the amount credited to the Account at a particular point in time. Thus, a Participant's Account may have a negative balance during a Plan Year, but any such negative amount shall never exceed the maximum dollar amount of benefits under this Plan elected by the Participant.

(b) **Crediting of Account**. A Participant's Medical Reimbursement Account will be credited periodically during each Plan Year with an amount equal to the Participant's Salary Reductions for benefits under this Plan.

(c) **Debiting of Account**. A Participant's Medical Reimbursement Account will be debited during each Plan Year for any reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year.

(d) **Forfeiture of Account**. If any balance remains in the Participant's Account for a Plan Year, after all reimbursements have been made for the Plan Year, including Qualified Reservist Distributions provided under Article V, Section 1(c), and the Deadline for Submission of Claims has elapsed, any such balance exceeding the maximum limit set annually by federal law shall not be carried over to the next Plan Year.

ARTICLE VI
CLAIMS AND APPEALS PROCEDURE

1. Claims for Benefits

The Plan Administrator shall prescribe the manner, method, and procedure for submission of claims for benefits. Appropriate forms for submission of claims will be supplied by the Administrative Agent.

2. Hearing and Appeal Provisions

The Plan Administrator shall prescribe the manner, method, and procedure for submission the submission of an appeal of an adverse determination by the Plan relating to eligibility or the entitlement to benefits pursuant to the terms of the Plan. The Benefits Booklet for the Plan shall contain a clear and concise description of the full and fair claims procedures, as amended from time to time by the Board of Trustees to comply with applicable State and federal law. The Benefits Booklet is incorporated herein by reference.

ARTICLE VII
ADMINISTRATION OF THE PLAN

1. Plan Administrator

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

2. Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as are considered necessary and appropriate to discharge its duties hereunder, including, but not limited to, the following discretionary authority:

(a) To construe and interpret this Plan and to decide all questions of eligibility and participation and all questions of benefits under this Plan;

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

(c) To prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Board of Trustees determines to be appropriate;

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

(e) To furnish to each Employee and Participant with reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

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

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

(h) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan; and

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

The Plan Administrator shall have the power to amend the Plan as deemed necessary, or to comply with the Code and regulations thereunder.

ARTICLE VIII
HIPAA PRIVACY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan's ability to use and disclose protected health information. The following definition of PHI applies to this Plan:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

It is the intent of the Plan to fully comply with HIPAA's requirements, including the Privacy and Security Rules and the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Board of Trustees and its designated staff shall have access to PHI only as permitted under this Plan Document or as otherwise required or permitted by HIPAA.

The Plan shall adopt a Privacy Policy and provide the Employee a Notice of Privacy Practices as required by HIPAA and shall make such Notice of Privacy Practices available for review by Plan Participants at the Administrative Offices. The Plan shall ensure that a Privacy Policy is in place governing the approved uses and disclosures of PHI by the Board of Trustees and its designated staff, in compliance with HIPAA and the interpretive regulations issued thereunder.

The Plan shall also ensure that all Business Associates of the Plan enter into a Business Associate Agreement as required by HIPAA and the HITECH Act, assuring that any uses or disclosures of PHI by the Business Associate are consistent with the permitted uses and disclosures set forth in HIPAA and comply with the "minimum necessary" requirement and documentation requirements of HIPAA.

ARTICLE IX
GENERAL PROVISIONS

1. Expenses

All administrative costs shall be borne by the Trust Fund.

2. Funding of this Plan

All of the amounts payable under this Plan shall be paid from the contributions paid to this Plan and by the Trust Fund. Nothing herein will be construed to require the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Plan, Plan Administrator or Trust Fund.

3. Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. However, the Board of Trustees may amend or terminate this Plan at any time.

4. Tax Consequences

The Plan Administrator makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal tax purposes. An Employee who uses the Health Care Reimbursement Account Plan to pay for eligible expenses cannot take a tax deduction on their federal income taxes for the year for the same expenses.

5. Non-Assignability of Rights

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

6. Gender and Number

Except when otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and the definition of any term herein shall also include the plural.

7. Headings

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

8. Plan Provisions Controlling

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

9. Counterparts

This Plan may be executed in counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute but one and the same document.

10. Interpretation of the Plan

The Named Fiduciaries shall have the sole and exclusive authority to interpret the terms and conditions of this Plan, to grant or deny eligibility for benefits in accordance with this Plan, and to interpret and apply their own administrative rules, regulations, contracts, instruments, or writings that they may have adopted or entered into in the furtherance of this Plan.

11. Severability

In the event any provision of this Plan shall be held illegal or invalid for any reason, this illegality or invalidity shall not affect the remaining provisions of this Plan, and such remaining provisions shall be fully severable and this Plan shall, to the extent practicable, be construed and enforced as if the illegal or invalid provision had never been inserted therein.

12. Code Compliance

It is intended that this Plan meet all applicable requirements of the Code, and the regulations thereunder. The Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

SIGNATURES

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan, the Board of Trustees as Plan Administrator executes this Amended and Restated Plan in its name and on its behalf effective January 1, 2021.

Shawn Staker, Chair   Date

Chelsea Sieh   Date

Charisse Millett   Date

Brittany Staker   Date

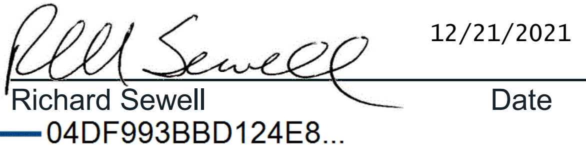
Richard Sewell   Date

Jodi Andres   Date

SIGNATURES

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan, the Board of Trustees as Plan Administrator executes this Amended and Restated Plan in its name and on its behalf effective January 1, 2021.

Shawn Staker, Chair	Date	Chelsea Sieh	Date
Charisse Millett	Date	Brittany Staker	Date



12/21/2021

Richard Sewell	Date	Jodi Andres	Date

SIGNATURES

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan, the Board of Trustees as Plan Administrator executes this Amended and Restated Plan in its name and on its behalf effective January 1, 2021.

Shawn Staker, Chair	Date	Chelsea Sieh	Date
Charisse Millett	Date	Brittany Staker	Date
Richard Sewell	Date	Jodi Andres	12/27/2021 Date