



Cottingham & Butler

# FSA

Welcome Packet & Eligible Expenses

User Guides

Online Portal | Mobile App

Submit Online Claim

Summary Plan Description & Plan Document

Additional Debit Card Request Form

Daycare Contract

Family Status Change Rules



# how **SMART** is your dollar?

MAXIMIZE your income with a FLEXIBLE SPENDING ACCOUNT

Benefit Coordinators Corporation's FSA administrative services paired with the industry-leading technology of My SmartCare makes it easier than ever to have Uncle Sam help pay for certain medical, dental, and optical expenses that are not otherwise covered by your insurance plans

[www.bccbenefitsolutions.com](http://www.bccbenefitsolutions.com)



**BCC'S TOLL-FREE CUSTOMER SERVICE CALL CENTER: 800-685-6100**

Monday - Thursday: 8:00am - 8:00pm ET / 5:00am - 5:00pm PT  
Friday: 8:00am - 6:00pm ET / 5:00am - 3:00pm PT





# SAVE on Predictable Expenses

Each one of us would like to have more money in our pocket. Participating in your company-sponsored Flexible Spending Account can do just that! What types of FSAs are available?

## ► Premium Conversion

This account type pays your medical, dental and vision plan contributions automatically on a before-tax basis. The monies withheld from your paycheck are used to pay the monthly premiums for these important employee benefits. The benefits you enjoy are two-fold: you are covered by the medical, dental, and/or vision plan AND you receive a tax break.

## ► Health Care Reimbursement

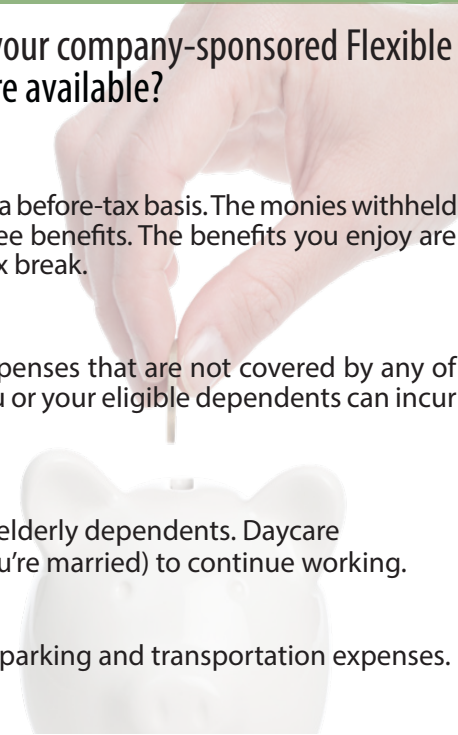
Use this account to pay for qualified, medically necessary medical, dental, or optical expenses that are not covered by any of your insurance plans. A partial list of eligible expenses is listed in this brochure. Either you or your eligible dependents can incur these expenses.

## ► Dependent Care Reimbursement

You can set aside funds annually to offset daycare expenses for your eligible children or elderly dependents. Daycare expenses are defined as those that are necessary in order for you (and your spouse, if you're married) to continue working.

## ► Parking & Commuter Reimbursement

If offered by your Plan Sponsor, you can reimburse yourself for a number of work-related parking and transportation expenses.



# CALCULATE your Estimated Expenses

Use these worksheets to estimate your annual expenses. Estimate conservatively, because any funds left in your account at the end of the Plan Year may be forfeited under IRS guidelines. Remember, calculated amounts cannot exceed the calendar year limits established by your plan sponsor and the IRS.

### HEALTH CARE REIMBURSEMENT ACCOUNT

Estimate the annual amount of uninsured expenses in the plan year:

Deductibles (medical, dental and vision)	\$ _____
Co-Payments (medical, dental and vision)	\$ _____
Routine Physical Exams Not Covered by Insurance	\$ _____
Dental and Orthodontia	\$ _____
Vision Care	\$ _____
Well-Baby Care	\$ _____
Prescribed Over-The-Counter (OTC) Drugs/Meds	\$ _____
Prescription Drugs (birth control included)	\$ _____
Other Allowable Expenses (see list)	\$ _____
<b>TOTAL</b>	\$ _____
<b>DIVIDE</b> by the number of paychecks you will receive during the plan year & round to the nearest whole dollar.*	\$ _____
<b>This is your per pay period contribution:</b>	\$ _____

### DEPENDENT CARE REIMBURSEMENT ACCOUNT

Estimate your eligible dependent care annual expenses for the plan year:

<b>CHILD CARE EXPENSES</b>	
Day Care Services	\$ _____
In-Home Care/Au Pair Services	\$ _____
Nursery & Pre School	\$ _____
After School Care	\$ _____
Summer Day Camps	\$ _____
<b>ELDER CARE EXPENSES</b>	
Day Care Center Services	\$ _____
In-Home Care	\$ _____
<b>TOTAL</b>	\$ _____
<b>DIVIDE</b> by the number of paychecks you will receive during the plan year & round to the nearest whole dollar.*	\$ _____
<b>This is your per pay period contribution:</b>	\$ _____

\* If you are a new employee enrolling after the Plan Year begins, divide by the number of pay periods remaining in the plan year.

FSA's offer employees a unique way to pay for certain necessary expenses with tax-free dollars. These examples help illustrate how you might see more money in your pocket by participating in a Flexible Spending Account

# a STRATEGY that works for EVERYONE



**ASSUMPTIONS ON THE CHART BELOW:**  
Single parent's estimated federal tax 15% and state tax 5%; dual income's estimated federal tax 25% and state tax 5%; full family's estimated federal tax 25% and state tax 5%. Note: Payroll calculations are for illustrative purposes only and normally vary by state and local taxing entities.

Christy is a divorced parent raising two children alone with an annual income of \$30,000. She uses her Premium Conversion Account to pay her monthly premium contributions for their group medical and dental plans. She uses the Health Care Reimbursement Account to receive reimbursement of their annual medical and dental deductibles. Christy uses her Dependent Care Reimbursement Account to pay for daycare expenses on a pre-tax basis. By participating in the Flexible Spending Account, Christy's spendable income is increased by \$158.99 per month.

Paul and Jenny are both employed, have two children, and have a combined annual income of \$76,000. They decide on a Premium Conversion Account to help pay the premium contributions for their dependent medical coverage. Their Dependent Care Reimbursement Account helps with their daycare expenses. One of their children is in braces, so they also use the Health Care Reimbursement Account to help pay orthodontic expenses not covered by their dental plan. By participating in the Flexible Spending Account, Paul and Jenny increase their spendable income by \$266.82 per month.

Mike and his wife Linda have two grown children that no longer live with them. Mike's annual salary is \$98,000 and he uses a Premium Conversion Account to pay for the monthly premium contributions for health care coverage for himself and his wife. He uses the Health Care Reimbursement Account to cover their annual medical and dental deductibles. By participating in the Flexible Spending Account, Mike's spendable income is increased by \$128.01 per month.

Pay Per Month	\$2,500		\$6,334		\$8,167	
Less Non-Taxable Benefits	without	with flex	without	with flex	without	with flex
Medical Premiums	--	\$115.00	-	\$185.00	-	\$140.00
Medical/Dental Expenses	-	\$60.00	-	\$125.00	-	\$200.00
Dependent Care Expenses	-	\$400.00	-	\$400.00	N/A	N/A
Total Pay Subject to Tax	\$2,500	\$1,925.00	\$6,334	\$5,624.00	\$8,167.00	\$7,827.00
<b>Less Tax Deductions</b>						
Federal & State	\$500.00	\$385.00	\$1,900.20	\$1,687.20	\$2,450.10	\$2,348.10
FICA	\$191.25	\$147.26	\$484.06	\$430.24	\$624.78	\$598.77
After Income Tax	\$1,808.75	\$1,392.74	\$3,949.74	\$3,506.56	\$5,092.12	\$4,880.13
<b>After Tax Expenses</b>						
Medical Premiums	\$115.00	-	\$185.00	-	\$140.00	-
Medical/Dental Expenses	\$60.00	-	\$125.00	-	\$200.00	-
Dependent Care Expenses	\$400.00	-	\$400.00	-	N/A	N/A
Spendable Income	\$1,233.75	\$1,392.74	\$3,239.74	\$3,506.56	\$4,752.12	\$4,880.13
Increased Spendable Monthly Income	\$158.99		\$266.82		\$128.01	

# BCC's **MY SMARTCARE** makes it **SIMPLE**

## ► **ONLINE & MOBILE ACCOUNT ACCESS**

We are all 'on the go', so why shouldn't our FSAs be too? The My SmartCare online portal and mobile app are fast, secure, and best of all - **CONVENIENT!** Check your account balance in real-time, file a claim for reimbursement by snapping a photo of the receipt, check on a claim status from anywhere, and more! It's that **SIMPLE!**

By registering with My SmartCare, you will begin receiving e-mail or text notifications (your choice) to help you manage your funds. You will be alerted of your account balance each month, when a manual claim begins processing, and when a debit card is mailed to you. The My SmartCare app is available for iOS and Android users.

## ► **BENEFITS DEBIT CARD CONVENIENCE**

The BCC benefits debit card has made spending your FSA funds easier than ever! If your plan-sponsor utilizes this feature, the card allows you to avoid out-of-pocket expenses, cumbersome paperwork, and reimbursement delays. Swiping your benefits debit card at the point of service deducts the payment directly from your account, giving you instant access to your FSA dollars. It can be used at all eligible FSA locations where Mastercard® is accepted.

One benefits debit card can manage multiple account types, such as a Healthcare Account, Dependent Care Account, Commuter Account, Health Reimbursement Account, or Health Savings Account. The My SmartCare online portal and mobile app support the use of this card by separating each of your account types for fast and easy review of all your funds in one place.

## ► **REIMBURSEMENT EASE**

If your plan-sponsor utilizes the benefits debit card, you can swipe your card at the point of service to automatically use your FSA funds. If you don't have your card with you or your plan does not include a debit card, you can simply use one of these methods to submit for reimbursement:

### **SUBMISSION THROUGH MY SMARTCARE:**

*(no Reimbursement Form required, uploaded photo of substantiation required)*

- My SmartCare Online Portal
- My SmartCare Mobile App

### **OTHER ELECTRONIC SUBMISSION:**

*(Reimbursement Form and photo of substantiation required)*

- E-mail: [fsa-claims@bccbenefitsolutions.com](mailto:fsa-claims@bccbenefitsolutions.com)

### **PAPER SUBMISSION:**

*(Reimbursement Form and photo of substantiation required)*

- Fax: 412-276-7185
- Mail: BCC, Attn: Claims

Two Robinson Plaza, Suite 200  
Pittsburgh, PA 15205

## ► **DIRECT DEPOSIT**

If you don't use your benefits debit card for payment or your plan-sponsor does not utilize a benefits card, you may have your reimbursement deposited directly into your checking or savings account. These transactions are reflected on the Explanation of Benefits (EOB). To enroll in this optional service, use the Reimbursement Settings in your My SmartCare account to set up your bank account information or obtain an authorization form from your HR Department and submit a completed copy to BCC.

## ► **FSA STORE**

BCC partners with the FSA Store to offer a simple, convenient way to use FSA dollars. This partnership gives you access to:

**Exclusive Discounts**  
on 4,000+ FSA  
Eligible Products

**Free Shipping**  
on orders of  
\$50 or more

**Full Eligibility List**  
to reduce FSA  
Eligibility Confusion

**24/7 Customer Service**  
through an Online Chat  
or Phone Call

Visit [fsastore.com/BCCOE](https://fsastore.com/BCCOE) to learn more!



# Q & A on Health Care FSAs

## How do I know how much money is in my account(s)?

You can check your balance through the My SmartCare online portal, mobile app, or by calling BCC's Customer Service Call Center. Once registered with My SmartCare, you will receive monthly balance reminders via e-mail.

## When can I start using my FSA funds?

You can access your entire annual contribution on the first day of your Plan Year. For example: if your Plan starts January 1st and you incur a large expense that day that is not covered by your insurance plan, you can submit the expense (up to your annual contribution amount) for reimbursement even though the Plan Year's contributions have not all been collected.

## Can I change my election amount mid-year?

No. Health care FSA election may only be altered if you experience a change in status as defined by IRS regulations (i.e. marriage, divorce, birth, or death in your immediate family). The change must be made within 30 days of experiencing the status change.

## What happens to the money left over when the Plan Year ends?

Check with your plan-sponsor for guidance on what happens to your unused funds when the Plan Year ends. Remaining funds may be forfeited under the IRS "Use It or Lose It" rule. Or, your plan-sponsor may have adopted a rollover provision or grace period.

## How do I determine the date my expense was incurred?

Expenses are incurred at the time that the service was provided, not when you are invoiced or when you pay the bill.

## Can I use my funds to pay for my family's qualifying expenses?

Your FSA funds cover eligible expenses for you and all of your dependents, even if you and/or your dependents are not covered under your Plan Sponsor's primary health plan.

## Do I choose Debit or Credit at the payment terminal when I use my benefits debit card?

Your benefits debit card can be swiped as either credit or debit at the time of purchase. If you choose to swipe as credit, you will need to sign for the purchase. If you choose to swipe as debit, you will need to enter your PIN number for purchase. To obtain the PIN associated with your card, you can use the My SmartCare online portal or mobile app. Your PIN is pre-determined at issue and cannot be customized.

## Can I get cash back at the point of sale or ATM with my PIN?

No. Your benefits debit card is only to be used for qualifying purchases and is not enabled for cash back.

## What do I do if I forget my benefits debit card PIN?

You can retrieve your PIN through the My SmartCare online portal or mobile app. For security purposes, neither BCC's Customer Service Call Center nor your HR Department have access to your PIN. If you forget your PIN, you can swipe your card as credit and sign for the purchase instead.

## How can I use my card if I receive a bill from a provider in the mail?

If the bill provides a space for payment via credit card, fill out that section with your card information OR call the provider for payment over the phone to provide payment information.

## What if the doctor's office does not take credit cards?

Cardholders would have to use another method of payment and then submit a manual claim.

## What should I do if I accidentally use the card for an ineligible expense?

You will receive a notice from BCC asking that you reimburse your account for the ineligible amount.

## Can I order additional cards for my family?

Yes, for your spouse or other eligible dependents (over the age of 18). You must complete and return a request form to BCC for processing and card generation.

## What do I do if my card is lost or stolen?

This must be reported to BCC via the My SmartCare online portal, mobile app, or by calling BCC's Customer Service Call Center. A replacement card will be ordered and the lost or stolen card will be deactivated.

## What do I do with my card after I've used all of my available funds?

Your benefits debit card is good for up to three years. Keep the card after you have used all of your available funds because you will be able to use it again next year for future Plan Years when you re-enroll.

## Do I still need to keep my receipts?

Yes. Although there is no requirement for you to complete claim forms and submit physical receipts, additional documentation may be requested in some cases to confirm the eligibility of a benefits debit card purchase.

## Why should I use my benefits debit card if I still might have to submit paper at a later date?

Not all transactions will trigger a request for substantiation. According to IRS Publication 969, "...If the use of these cards meets certain substantiation methods, you may not have to provide additional information to the health FSA." BCC's hosted debit card system works in conjunction with registered IAS terminal merchants to help ensure cards are used for eligible expenses only.

## My transaction is a Code S213(d) medical expense. Why did I receive a letter requesting additional documentation?

To ensure compliance with IRS guidelines, BCC must perform audits on large dollar claims and amounts over \$50.00 at certain locations where it is not readily discernible as to the use of the funds. Additional audits may also be performed to ensure the integrity of the claims payment process.

## My benefits debit card transaction already went through and payment was made. What happens if I don't respond to BCC's request for documentation?

Failure to provide appropriate documentation within 30 days from the date of the initial request will result in the benefits card being made temporarily inactive. Claims will then only be processed via the regular request for reimbursement method until appropriate documentation is received, reviewed, and approved.



# HEALTH CARE FSAs

## ELIGIBLE EXPENSES

- Acupuncture
- Adoption, Pre-Adoption medical expenses
- Alcoholism Treatment
- Ambulance
- Artificial teeth & limbs
- Asthma treatments
- Bandages, elastic, gauze pads, liquid adhesives for small cuts
- Blood pressure monitoring devices
- Breast pumps and lactation supplies
- Carpal tunnel wrist supports
- Chiropractors
- Circumcision
- Co-insurance amounts
- Cold/hot packs
- Contact lenses, materials and equipment
- Contraceptives
- Co-payments
- Crutches
- Deductibles
- Dental sealants
- Dental treatment (excludes cosmetic)
- Dentures and denture adhesives
- Drug addiction treatment
- Egg donor fees
- Eye examinations and eyeglasses
- Feminine Care Products
- First aid (creams and kits)
- Flu shots
- GIFT (Gamete Intra-Fallopian Transfer)
- Guide dog
- Hearing aids
- Hospital services
- Immunizations
- Laboratory fees
- Lasik eye surgery
- Medical information plan charges
- Medical monitoring and testing devices
- Medical records charges
- Norplant insertion or removal
- Obstetrical expenses
- Occlusal guards to prevent teeth grinding
- Operations (excludes cosmetic procedures)
- Organ donors
- Orthodontia
- Osteopath fees
- Over-the-Counter drugs
- Oxygen
- Physical exams
- Physical therapy
- Pregnancy Test Kits
- Preventive care screenings
- Prosthesis
- Psychiatric care
- Radial keratotomy
- Shipping and handling fees
- Sterilization procedures
- Sunscreen (SPF 15+)
- Taxes on medical services and products
- Termination of Pregnancy

- Thermometers
- Transplants
- Transportation expenses for person to receive medical care
- Usual and customary charges
- Vaccines
- Viagra
- Walkers
- Wheelchair
- X-ray fees

## EXPENSES REQUIRING A LETTER OF MEDICAL NECESSITY

- Arthritis gloves
- Braille books and magazines
- Breast reconstruction surgery following mastectomy
- Chelation therapy
- Fluoridation devices or services
- Herbal Supplements
- Learning disability, instructional fees
- Massage therapy
- Medical alert bracelet or necklace
- Patterning exercise
- Television or telephone for hearing impaired persons
- Vitamins

### What is a letter of medical necessity?

The IRS mandates that eligible expenses be primarily for the diagnosis, treatment, or prevention of disease or treatment of conditions affecting any functional part of the body. For example, vitamins are not typically covered because they are used for general wellness, but your doctor may prescribe a vitamin to treat a medical condition. The vitamin would then be eligible if your doctor verified the necessity of treatment.

## EXPENSES REQUIRING A PRESCRIPTION

- Antibiotics
- Anxiety medication
- Blood pressure medication
- Heart Disease medication
- Steroids

## EXPENSES **NOT** ELIGIBLE FOR REIMBURSEMENT

- Insurance premiums
- Elective cosmetic surgery
- Expenses reimbursed by another insurance or FSA
- Expenses not qualified by the IRS
- Expenses claimed as deductions or credits on your federal tax return
- Expenses incurred before you were a participant in the FSA plan
- Expenses incurred when you are no longer a participant in the FSA plan
- Amounts above the maximum plan limits for medical reimbursement



# HEALTH CARE FSAs

## SUPPORTING DOCUMENTATION GUIDELINES

### Required for Most Health Care Services:

- All PPO Services: Explanation of Benefits (EOB) from the insurance carrier
- Non-PPO Services: Itemized bill or receipt from service provider that includes all of the following:
  - Name of Service Provider
  - Name of Patient
  - Date of Service
  - Details of Service or Product
  - Cost of Service or Product
- **DO NOT SUBMIT:** Cash Register Receipts, Balance Forward Statements, Cancelled Checks, Credit Card Receipts/Statements, Received-on-Account Statements, Estimates for Services to be Performed

### Required for an Office Co-Pay:

- Receipt or Invoice that includes all of the following:
  - Name & Address of Service Provider (pre-printed or stamped)
  - Name of Patient
  - Date of Service
  - Wording indicating that it is a co-pay or office visit
  - Cost of Co-Pay
- **DO NOT SUBMIT:** Cash Register Receipts, Balance Forward Statements, Cancelled Checks, Credit Card Receipts/Statements, Received-on-Account Statements

### Required for Prescriptions:

- A copy of the itemized prescription label (often attached to the outside of the bag upon purchase) or mail-order prescription invoice that includes all of the following:
  - Name of Pharmacy
  - Name of Patient
  - Date of Purchase
  - Name of Drug
  - Cost of Prescription (if not subject to co-pay)
- **DO NOT SUBMIT:** Cash Register Receipts, Balance Forward Statements
- If you do not have a copy of the label, contact your pharmacy

### Special Circumstances:

- Orthodontia: Requires an Orthodontia Financial Agreement each Plan Year (contact BCC's Customer Service Center regarding this document)
- Some expenses require a letter from your doctor each Plan Year (ex: Hypnotherapy, Massage Therapy, Support Hose, Weight Loss)

## RULES TO REMEMBER

Participants must actively enroll in an FSA plan each year. FSA Enrollment does not automatically carry forward from one Plan Year to the next.

Once FSA contributions begin, an election can change **ONLY** if a change in family status occurs, as defined by the IRS. This includes marriage, divorce, birth or adoption of a child, or the death of a dependent.

IRS regulations very clearly define FSA rules because you are affecting your taxable income by contributing to an FSA. You must keep these rules in mind when you are planning your contributions and using FSA funds.

Be aware that when taxable income decreases, one's Social Security contributions decrease. This reduction of Social Security (FICA) contributions may affect future retirement or disability benefits.

Estimate your annual contributions conservatively as unused funds at the end of the Plan Year may be forfeited under the IRS "Use It or Lose It" Rule. Check with your plan-sponsor on any available rollover provisions or grace periods.

If enrolled in more than one FSA category, reimbursement can only occur from the account for which the contribution was designated. In other words, if a contribution is made to both Health Care and Dependent Care Accounts, reimbursement for a dependent care expense cannot occur from the Health Care account.





# DEPENDENT CARE reimbursement

## ELIGIBLE DEPENDENT CARE EXPENSES

- Child Day Care Services
- In-Home Child Care/Au Pair Services
- Nursery & Preschool
- After School Care
- Summer Day Camp
- Elder Day Care Center & In-Home Care

## EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- Food
- Clothing
- Entertainment
- Education (expenses to attend kindergarten or higher)
- Activity Fees
- After School Educational Classes/Homework Clubs
- Tutoring Costs
- Late Payment Fees (for eligible dependent care expenses)

## SUPPORTING DOCUMENTATION GUIDELINES:

### Dependent Care Documentation Must Show:

- Name of Dependent(s)
- Begin & End Date of Service
- Provider Tax ID Number for health care facility OR Social Security Number for individual service providers
- Amount Incurred
- Signature of Provider

### Do NOT Submit:

- Copies of Checks/Cancelled Checks (copies of cancelled checks are acceptable so long as both the front and back of the cancelled check are copied)
- Balance Forward Statements
- Credit Card Statements (Cash register receipts & credit card receipts are acceptable, provided that they are detailed & the request form is itemized)
- Estimates for Services to be Performed

### Special Circumstances:

- Reimbursement requests received incomplete or without proper documentation will be returned unprocessed
- You may only be reimbursed for current or previous dependent care expenses
- Keep originals for your records as supporting documents become part of your claim and will not be returned
- Reimbursements will be sent to your home address unless the direct deposit feature is available under your Flexible Benefits Plan and is requested

## WHAT IS THE FSA DEFINITION OF "DEPENDENT"?

- he/she must be your dependent,
- under the age of 13 when the care is provided, AND
- for whom you can claim an exemption, OR
- your spouse who was physically or mentally unable to care for him/herself

*\*For more in-depth information or clarification on elder care as a qualified expense, consult your tax advisor*



# PARKING & COMMUTER reimbursement

## ELIGIBLE VEHICLE & BICYCLE PARKING EXPENSES (if your Plan Sponsor offers this benefit)

- Fees for parking that is located on or near employer's premises
- Fees for parking at or near a mass-transit location (allowing you to commute via mass-transit)
- Fees for parking at or near a van-pooling or car-pooling meeting site
- Parking provided to you where your employer pays directly to a parking lot operator
- Parking that an employer provides on its premises that requires a lease

## DO I HAVE THIS BENEFIT?

Your Plan Sponsor (employer) decides if a Parking or Transportation benefit is offered. Check your Plan Document or contact your HR Department for more information.

## ELIGIBLE COMMUTER EXPENSES (if your Plan Sponsor offers this benefit)

- Transit Pass
- Transit Token
- Transit Fare-Care
- Transit Voucher
- Van-Pooling
- Commuter Highway Vehicle Expense\*
- Similar items may also be eligible pending approval from your Plan Sponsor

*\*A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults, not including the driver, used for travel between the employee's residence and place of employment.*

*Expenses must be provided by a Mass Transit Facility of Qualified Van Pooling Service*

## EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- EZ Pass
- Highway Tolls
- Bicycle purchase, maintenance, supplies, or accessories
- Parking expenses cannot be reimbursed from a Commuter Benefit (i.e. if you pay to park at a mass transit pick-up location, the parking expense cannot be reimbursed under your Commuter Plan; the parking expense can only be reimbursed if you are enrolled in a Parking Benefit Plan)

## SUPPORTING DOCUMENTATION GUIDELINES FOR PARKING & COMMUTER EXPENSES:

### Parking & Transportation Documentation Must Show:

- Date(s) of Service
- Amount Incurred

### Do NOT Submit:

- Cancelled Checks
- Credit Card Statements (Cash register receipts & credit card receipts are acceptable, provided that they are detailed & the request form is itemized)

### Special Circumstances:

- If you cannot obtain a receipt, you must complete and sign the Employee Certification section AND the Authorization section of the Reimbursement Form. Examples of this instance include paying via parking meter or paying via coin box.



# EMPLOYEE FAQ: Health Care Flexible Spending Accounts (HCFSA)

## What is a HCFSA?

A Health Care Flexible Spending Account (HCFSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible health care expenses.

## Why should I participate in an HCFSA?

Contributions to the HCFSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You can increase your spendable income by an average of 30% of your annual contribution with tax savings.

## How do I contribute money to my HCFSA?

Your annual election will be divided by the number of pay periods in your Plan Year. This amount will be deducted from your paycheck before taxes are assessed.

## How much can I contribute to my HCFSA?

The IRS sets the annual HCFSA contribution maximum. That amount is subject to indexing each year by the IRS. Your employer will provide you with information on your Plan's maximum amount available each Plan Year.

## Who is eligible under an HCFSA?

An HCFSA covers eligible expenses for you and all of your dependents, even if you and/or your dependents are not covered under your primary health plan.

## What expenses are eligible for reimbursement?

Expenses such as health plan co-pays, deductibles, co-insurance, eyeglasses, dental care, and certain medical supplies are covered. The IRS provides specific guidelines regarding eligible expenses (See IRS Publication 502).

## Can health insurance premiums be reimbursed?

The IRS does not allow reimbursement for any health insurance premiums under the HCFSA.

## How do I determine the date my expenses were incurred?

Expenses are incurred at the time that the service was provided, not when you are invoiced or when you pay the bill.

## How do I get the funds out of my HCFSA?

If you have a benefits debit card, simply swipe it at the register and keep your receipt should claim documentation be required. Otherwise, file a claim through the My SmartCare online portal/mobile app or by mail, fax, or e-mail (including the receipt documenting the service type, amount, and date). Once approved, your reimbursement check will be mailed or you will receive a direct deposit into your designated bank account.

## What happens if I don't spend all of my HCFSA dollars by the end of the Plan Year?

Be sure to only allocate dollars for predictable health care expenses. Any unused funds at the end of the Plan Year are typically forfeited under the 'Use-It-or-Lose-It' IRS rule. Check your SPD or My SmartCare for the time limits in which you can incur and submit claims under your Plan.

## How soon can I start spending my HCFSA funds?

Your entire annual election amount is available on the first day of the Plan Year even though you have not yet contributed yet.

## Can I change my election amount mid-year?

Elections may only be altered if you experience a change in status as defined by IRS regulations (i.e. marriage, divorce, birth, or death in your immediate family). The change must be made within 30 days of experiencing the status change.

## What happens to my HCFSA if my employment is terminated?

Participation in your HCFSA is also terminated. This means that only expenses incurred prior to your termination date are eligible for reimbursement. Please refer to your SPD for specific HCFSA termination rules.

## What is the deadline to submit HCFSA claims?

You can submit claims at any time during the same Plan Year that you incurred the expense. Please refer to your SPD to see if your Plan allows for a Grace Period.

## Can I still deduct health care expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your HCFSA.

## Are Over-The-Counter (OTC) medications eligible expenses?

Yes, with a doctor's prescription. You will need to submit a claim with the receipt for the OTC medication along with the prescription from your doctor that includes the diagnosis and course of treatment in order to receive reimbursement.

## What is a 'Letter of Medical Necessity'?

The IRS mandates that eligible expenses be primarily for the diagnosis, treatment, or prevention of disease or treatment of conditions affecting any functional part of the body. For example, vitamins are not typically covered because they are used for general wellness, but your doctor may prescribe a vitamin to treat a medical condition. The vitamin would then be eligible if your doctor verified the necessity in treatment.





# My SmartCare Online Portal

Simplify your healthcare finances with convenient, online access to your tax-advantaged benefit account.

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## Getting started

Visit <https://benefitcc.wealthcareportal.com/Page/Home> to access the My SmartCare Portal.

### Registration

**Step 1:** Click **register** to create an account

**Step 2:** Complete your registration in a few easy steps.

1. Enter your **name** and **zip code**. If you have received a benefit debit card, check the box to **enter the card number** and expedite the registration process.
2. We'll send you a special code for verification. Check your email or text messages and **enter the code** provided.
3. **Create** a username and password for your account.
4. **Select** four security questions and **provide** your answers. For your security, these questions may be randomly asked during subsequent logins.
5. **Confirm** your email address.
6. Review your answers and **submit** your registration.

**Step 3:** Once you've successfully registered, click **done** to sign in.

### Signing in

Enter the **username** and **password** you created. You may be asked to **answer** your security questions or enter a one-time passcode, sent to you via email or SMS text.

We will maintain the confidentiality of your personal information in accordance with our privacy policy.

Sign in

Username \*

johndoe123

Forgot your Username? [Let us help](#)

Password \*

.....

Forgot your Password? [Let us help](#)

✓ SIGN IN

Don't have an account?

REGISTER

STEP 1 STEP 2 STEP 3 STEP 4 STEP 5 STEP 6

You are on step 1 of 6

Let's get you registered - please provide the information below.

First Name \* Maura

Last Name \* TestTwelve

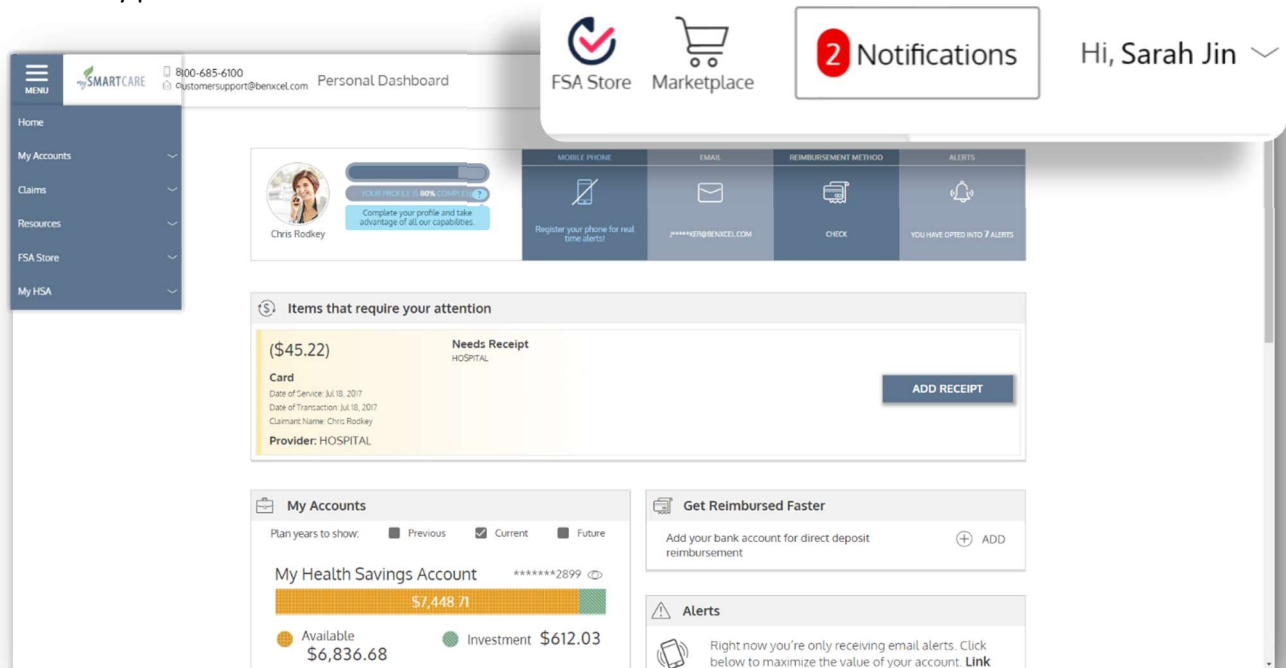
Zip Code \*

Check this box if you received a debit card for your benefit account.

✕ CANCEL ✓ NEXT

## Menus

With My SmartCare Portal you can manage your healthcare spending accounts, claims and transactions in one easy place.



Use the icons in the upper right of the screen to shop with your benefit accounts, view notifications, or edit your profile.



FSA Store

### *FSA Store*

Click the **FSA Store** icon to shop for FSA-eligible products.



### *Notifications*

Click **notifications** to view your news and alerts. The number in red tells you how many unread notifications you have.



Marketplace

### *Marketplace*

Click the **marketplace** icon to access the CDH marketplace where you can use your eligible FSA and HSA accounts for purchases.




### *Drop-down menu*

Click the **drop-down menu** to access your:

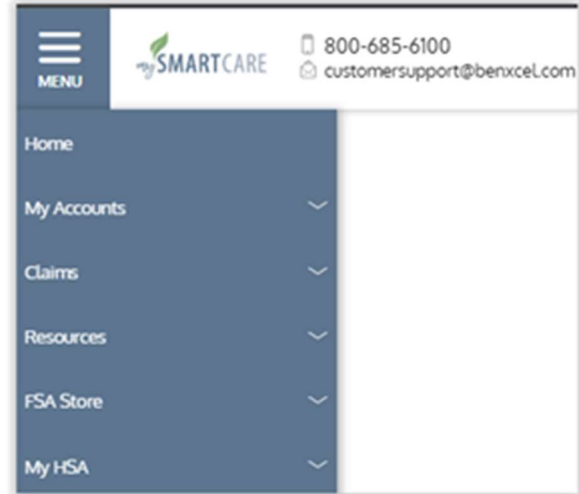
- Profile
- Debit card information
- Communication settings
- Contact us
- Log out

### Main menu

Expand the hamburger **menu** on the upper left of your personal dashboard to navigate to your accounts, claims and other resources.

Click  to expand the menu.

Use the **home** button to return to the main screen of your personal dashboard from any other screen within My SmartCare Portal.

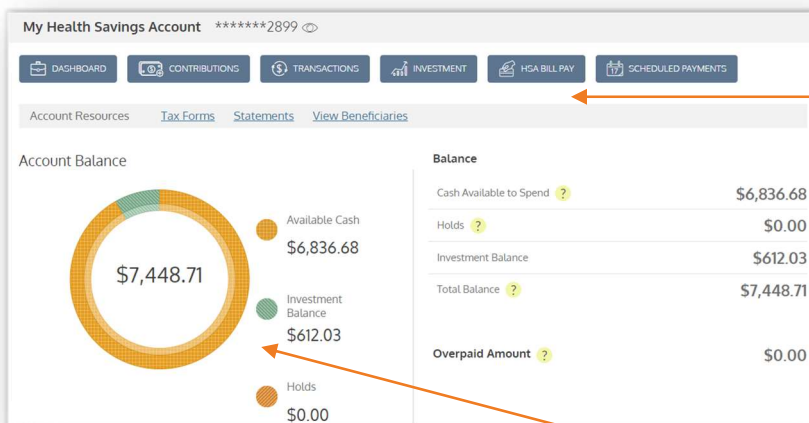


### Checking your account balance(s)

The benefit account summary page provides a quick view of your account balance(s).

Get there by clicking on the account that you want to view.

Each of your accounts displays in its own box with the account type listed on top. A flexible spending account (FSA) is displayed in the image below.



Quick links to additional account details, a list of transactions, claim submission, and other tools!

Your **annual** election balance, split into how much has been spent and how much is still available to spend.

## Submitting a claim or expense

The *add expense* wizard will walk you through a series of questions to help you submit your request correctly. You can use this wizard for **reimbursement requests** or to **pay a provider** for an eligible cost.

To use the expense wizard, click **menu > claims > submit claims**.

Payments can be made directly to your provider or yourself. When paying yourself, you may choose to receive a check via mail or set up direct deposit to your bank account.

Add claim for immediate reimbursement

CLAIM DETAILS > DOCUMENTATION > CONFIRM SUBMISSION

**i** Claim Form Instructions

**i** Please make sure to complete all fields below.

\* - Required Field

**i** Service Start Date \*

**i** Service End Date

**i** Claimant

**i** Reimbursement Method

**i** Account Type \*

**i** Claim Amount \*

**i** Provider Name

**i** Account Number

**i** Comments

You may attach receipts to your claim and expense entries to validate, if necessary.

Add claim for immediate reimbursement

CLAIM DETAILS > DOCUMENTATION > CONFIRM SUBMISSION

**i** Please Choose a Validation Method to Continue

**i** Attach Claim Receipt  
Take a photo of your receipt or attach an existing document now.

**i** Validate Later  
Submit the claim without a receipt now, knowing a receipt may be required for claim approval.

**X** CANCEL

ABOUT US   TERMS OF USE   PRIVACY POLICY  
Copyright © 2017 Benefit Coordinators Corporation (BCC). All Rights Reserved.  
Contact Customer Care: 888-897-3788 | beta.myhealthcareonline.com/bccsmartcare/

## Viewing claims and expenses

View claims and transactions on the *transactions* page. Use the buttons on top to filter transactions by year, plan, status and more!

To view, click **menu > my accounts > transactions**.

800-685-6100  
customersupport@benxcel.com Transactions PSA Score

Year  Plan  Type  [EXPORT TO EXCEL](#)

Which transactions do you want to see? Select activities  Approved/Posted  Pending/Processing  Authorized  Denied [SEARCH FOR TRANSACTIONS](#) [PRINT TRANSACTIONS](#)

\$33.96	My Health Savings Account Posted	Interest payment INTEREST PAYMENT	Feb 28, 2023
\$37.38	My Health Savings Account Posted	Interest payment INTEREST PAYMENT	Jan 31, 2023

Click on an individual transaction to view its **details** and take action, as needed. Based on your policy and purchases, transactions may be marked as Approved, Pending, Action Required, or Denied.

Which transactions do you want to see? Select activities  Approved/Posted  Pending/Processing  Authorized  Denied [SEARCH FOR TRANSACTIONS](#) [PRINT TRANSACTIONS](#)

\$33.96	My Health Savings Account Posted	Interest payment INTEREST PAYMENT	Feb 28, 2023
Date Of Service	Feb 1, 2023		RECEIPTS
Description	INTEREST PAYMENT		No receipts to display. <a href="#">PRINT</a>
Claimant	Chris Rodkey		
Account	My Health Savings Account		
Payment made to provider?	No		
Plan Start Date	Jan 1, 2017		
Plan End Date	Dec 31, 2099		
Merchant Name	INTEREST PAYMENT		
HSA Type			
HSA Posting Date	Feb 28, 2023		

[ADD RECEIPT](#)

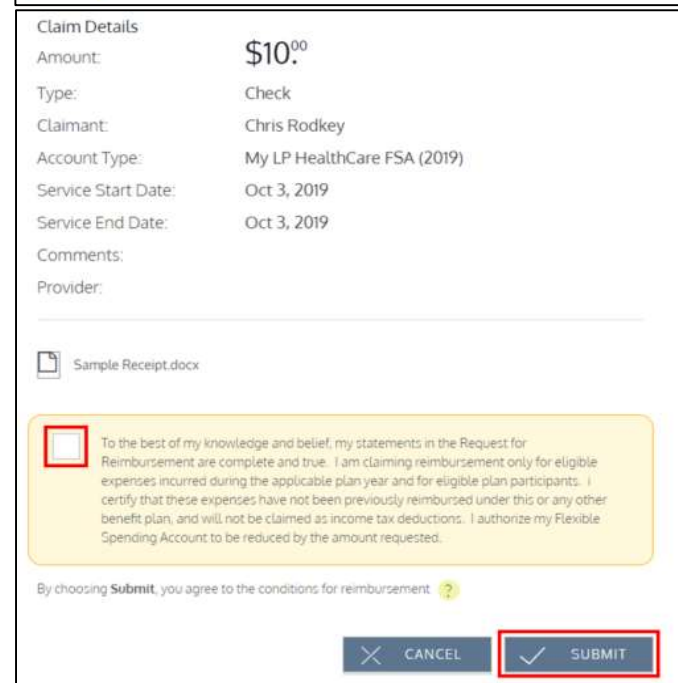
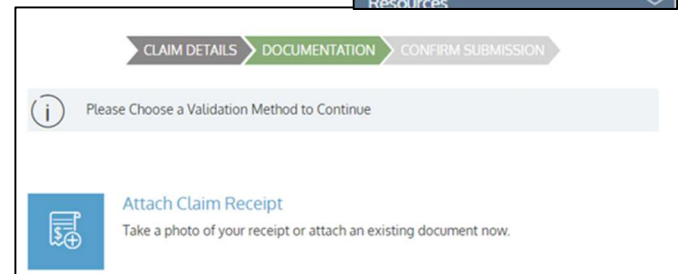
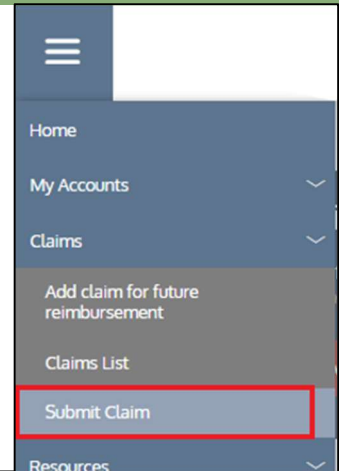
If a receipt is required, the option to attach one will show within the transaction. Adding a receipt may also help resolve pending transactions faster.

Click **add receipt** to attach your document for review.

# Instructions for Online Claims Submission

In order to use this feature, you must be registered with My SmartCare. If you do not have an account, simply go to <https://benefitcc.wealthcareportal.com/Page/Home> and click REGISTER. When creating your account, use your Social Security Number as your Employee ID and use your Benefits Debit Card Number as your Registration ID. You can also register through the My SmartCare mobile app.

- Click your MENU icon at the top left corner of your screen.
- Click CLAIMS to expand the menu, and then click SUBMIT CLAIM.
- The CLAIM DETAILS screen will appear. Complete as much of the electronic form as possible.
  - All required fields are marked with (\*).
  - Use the COMMENTS section to provide any additional information on your claim that was not included in the form, but that may be helpful for processing purposes.
- Click NEXT.
- The DOCUMENTATION screen will appear. Click ATTACH CLAIM RECEIPT to upload a copy of your receipt (or other documentation) into your claim
  - Uploaded files must be the following types: .pdf, .jpg, .jpeg, .gif, .png, .tif, .tiff, .xls, .xlsx, .doc, .docx
  - If you do not have any receipts for your claim, it will likely be denied due to lack of substantiation.
- Click NEXT.
- A CONFIRM SUBMISSION screen will appear for you to review your claim details for accuracy.
- Read the important message in the yellow agreement and acknowledgement box. Check the box if you agree.
- Click SUBMIT.
- A THANK YOU message will appear once your claim has been successfully submitted to BCC for processing.

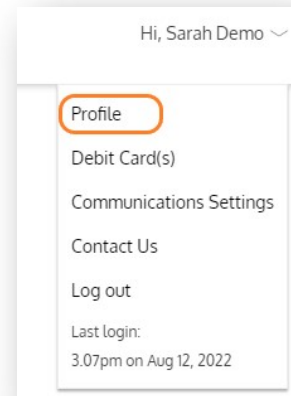


## Your user profile







Click the drop-down next to your **username** and select **profile** to view your personal information.

From this page, you can see your:

- Phone number and address
- Reimbursement method
- Dependent information
- And more!



To change your personal information, click **edit profile** from within your profile page, or **edit dependent** from your list of dependents below.

 <p><a href="#">change picture</a></p> <p>Chris Rodkey</p> <p>Date of Birth Dec 7, 1980</p> <p>Marital Status None</p> <p>Gender None</p>	<p> Phone</p> <p>Mobile Phone</p> <p>Email Address <a href="#">edit</a> j*****ker@benxcel.com</p> <p> Employer</p> <p>Acme Widget Company</p> <p>Employee Status Active</p>	<p> Home Address</p> <p>10 Main Street Beverly MA, 00000 US</p> <p><a href="#">change password</a> <a href="#">delete account credentials</a></p> <p> <a href="#">edit</a></p> <p>Reimbursement Method Check</p>
<h3>Family Members</h3>		
<p> Samantha Rodkey      Spouse Or Common Law Spouse</p>		



**Note:** You can update your **mobile phone number** from within your profile, however, you may still need to update your SMS notifications within the **communication settings** page to change your alert preferences.

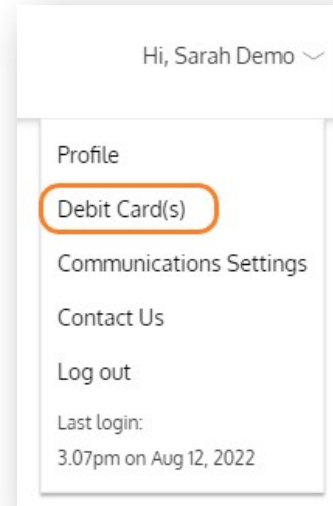
## Debit cards



You can view the benefit account debit cards that have been issued to you and your dependents from within My SmartCare Portal.

To view your benefit account debit cards, click the drop-down by your **username** and select **debit cards**.

Click on an individual card to view more information. From here you can:

- Activate a new card
- View the card pin
- Report the card lost or stolen



	**** -1642	New	Lente Dutch	
	**** -0084	New	Eliza Kid	<input checked="" type="checkbox"/> ACTIVATE <input type="checkbox"/> VIEW PIN <input type="button" value="REPORT LOST / STOLEN"/>
Issue Status:	Sent	Activation Date:		
Mailed Date:		Expiration Date:	Mar 31, 2024	

## Managing alerts & messages

The notification center is your place to view account messages, items awaiting action, and potential opportunities.






To view, click **notifications** on your **personal dashboard**. The number in red alerts you of unread notifications.

Click on an **individual message** to see the full text.

You have **12** Notifications to view.

The notification center is your place to view information about your benefit accounts activity, review items that need to be taken care of, and see potential opportunities to maximize your overall benefit account experience.

View **All** Messages Opportunities

	acct bal stmt TEST	Dec 1, 2021
	Your Recent Health Financial Account Claim	Nov 17, 2021
	acct bal stmt TEST	Nov 1, 2021

*Messages* provide important information about your account(s). Be sure to check your notifications for crucial messages.



*Opportunities* are tips and tricks that can help you maximize your benefit accounts, such as suggesting to switch to direct deposit reimbursements or electronic-only statement delivery.


### Changing your alert preferences

Change your alert preferences from the communication settings page. Click the drop-down next to your **username** and select **communication settings**.

For each alert, choose whether you receive mobile, email, both, or no notifications.

Click **save** when you are done editing your preferences.

You can also update your email address and register your mobile phone for SMS text alerts.

Hi, Sarah Demo 

- Profile
- Debit Card(s)
- Communications Settings**
- Contact Us
- Log out
- Last login:  
3.07pm on Aug 12, 2022

Assigned Notifications



You are opted-in to one or more mobile communications, but do not have a mobile number registered. You will not receive these communications unless you register a mobile number.



The notifications below are available to you. Please define the delivery method for each notification you wish to receive. Please ensure you have an email address and/or registered mobile in order to receive these notifications.

- mobile
- email
- both
- none

- Account Balance Alert**  
This communication is sent when your account balance falls below \$50.00.  
 mobile  email  both  none
- Account Balance Statement**  
This communication is sent on a Monthly basis.  
 mobile  email  both  none
- Card Mailed**  
This communication is sent when your card has been mailed.  
 mobile  email  both  none
- Enrollee Welcome Email**  
This communication is sent when your account is created.  
 mobile  email  both  none

SAVE

Email Address

e\*\*\*l@email.com

Phone Registration Status

ADD NUMBER



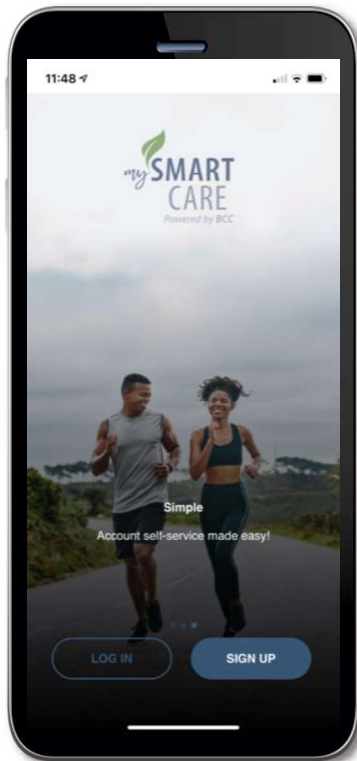
# BCC My SmartCare App User Guide

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## BCC My SmartCare App

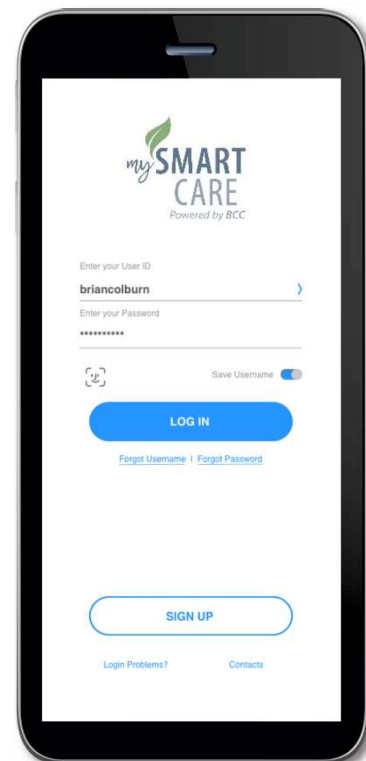
Managing your benefit account(s) on-the-go is made easy with the BCC My SmartCare app. This powerful, intuitive mobile app gives you access to view your account balances, update your profile, submit a claim, and much more, right from your Android or Apple mobile device. The BCC My SmartCare app provides a personalized experience and delivers meaningful insights to better guide your healthcare spending. The app also offers recommendations for savings on healthcare items such as prescription medications. This guide is intended to provide an overview of the BCC My SmartCare app features so you can be sure you are getting the most from your benefit account(s).



### Getting Started

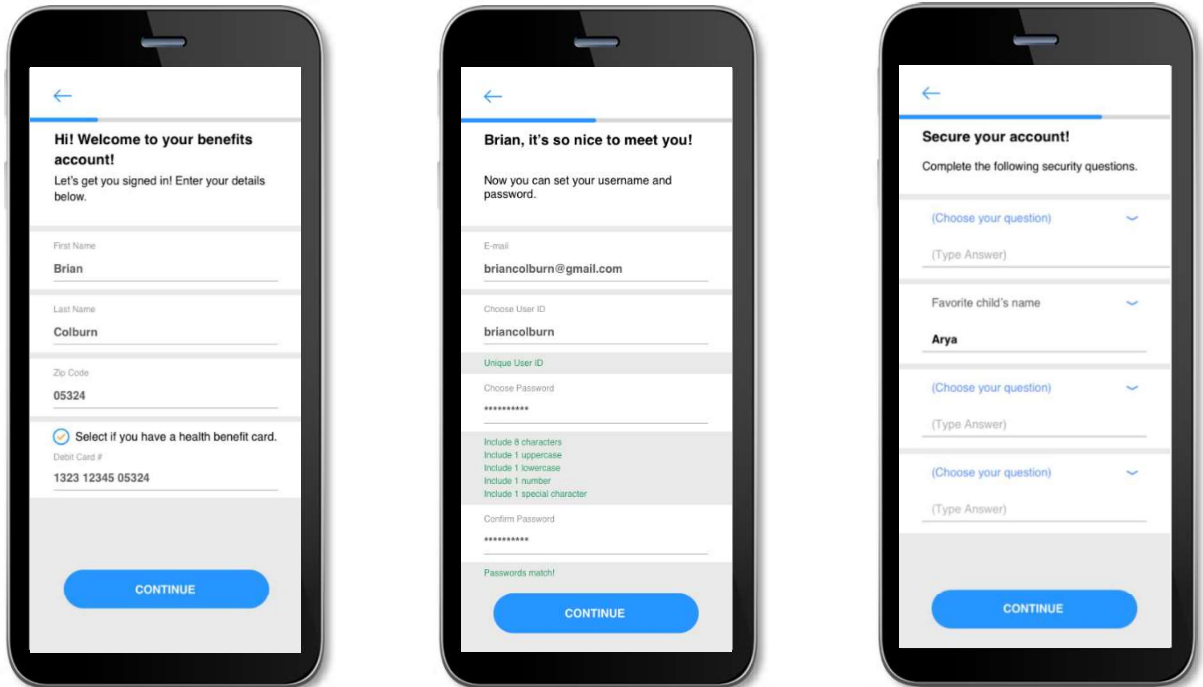
Your login credentials for the My SmartCare web portal and BCC My SmartCare app are the same. After downloading the app, you will see a landing page with options for 'log in' and 'sign up' as shown in the image to the left.

- If you already have a My SmartCare user ID, you can enter it and tap log in. You may be asked some security questions and then be prompted to enter your password.
- If needed, you can retrieve a forgotten user ID from the sign-in screen and reset a forgotten password from the password entry screen.
- If this is your first-time logging into the My SmartCare web portal and the My SmartCare app, you must register before you can access the application.



## Registration

After tapping the 'Sign Up' button on the home screen, you will be guided through the registration steps.



Begin the registration process by entering the required information. If you have your benefits debit card number handy, then you only need to enter your name, zip code and card number. You are then guided by the My SmartCare app to confirm your identity, create a user ID, and choose and confirm a password that meets the provided specifications. **Note:** These login credentials can be used to access both the My SmartCare app and web portal.

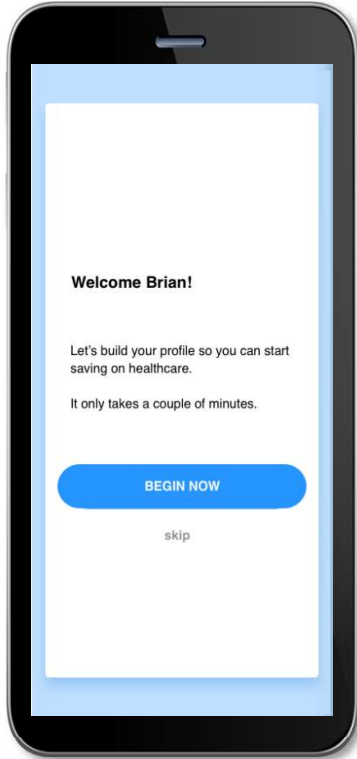
If you do not have a card or do not have your card number available, but you have an email or mobile phone number on file, you will be directed to confirm your email or mobile phone number where you will receive a security code verification. If you do not have an email or mobile phone number on file, you will be prompted to enter your *employer and employee ID (SSN)*. If you do not know your employer ID, you may obtain it from your employer.

To secure your account, select and answer four security questions. You can confirm that all your information has been entered accurately before moving on to the email or text confirmation steps.

These same steps are required when registering on the My SmartCare web portal.

### Biometric Verification

If your device uses biometric verification you can opt to enable this functionality to access the My SmartCare app. Simply choose to save your user ID on the *Log In* screen, and after signing in, you will be presented with the option to enable touch/face recognition access. You can view your touch/face recognition access status and disable it at any time via the 'Settings' screen.



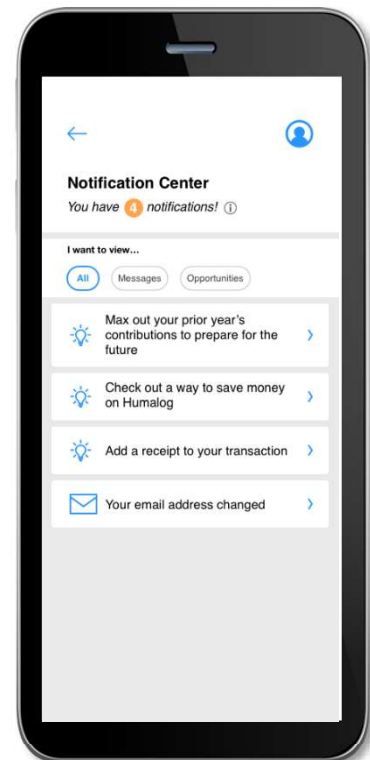
## Onboarding

After registering, or successfully logging into the app for returning users, you will be guided through an onboarding process. Onboarding will help improve the usefulness of the app and personalize it to your needs. You may opt out of the onboarding process, if you prefer, and you can later personalize the app through *opportunities* found in the *Notification Center*.

## Notification Center and Opportunities

The My SmartCare app has a *Notification Center* which is present at the top right corner of every screen within the app. This notification center allows you to view not only pertinent alerts, but also *opportunities*. The opportunities are personalized to you, your account needs, and your app settings.

1. You may click on the *Notification Center* icon at any time to view your *opportunities* list
2. Clicking on one of the individual opportunities will open the specified page
3. The page associated with the chosen opportunity will coach you through the steps to maximize your savings



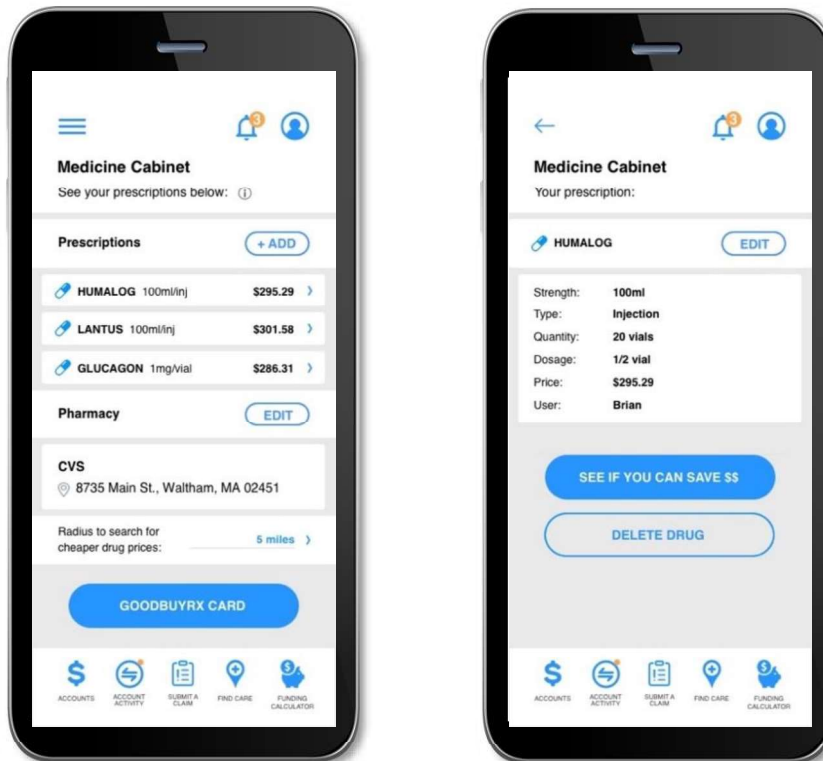
## Medicine Cabinet

The My SmartCare app also includes a *Medicine Cabinet* feature which can be accessed from the main menu screen. You will also be prompted by the *opportunities* feature to enter your medications into the *Medicine Cabinet* if you did not do so during onboarding. The My SmartCare app will find cost-saving opportunities on your drugs. You can also set up your home pharmacy in the *Medicine Cabinet* in order to retain a search location and radius for more drug savings opportunities.

Once you complete the setup of your *Medicine Cabinet*, you will see a listing of all your drugs and their prices. You may also edit, delete, or add drugs or the price you paid for them at any time. The My SmartCare app helps you capture the most recent information about how much you are paying for your medications.

If applicable, the My SmartCare app may notify you if a cheaper alternative is available for any of your medications saved in the *Medicine Cabinet*.

Below are some example screenshots:

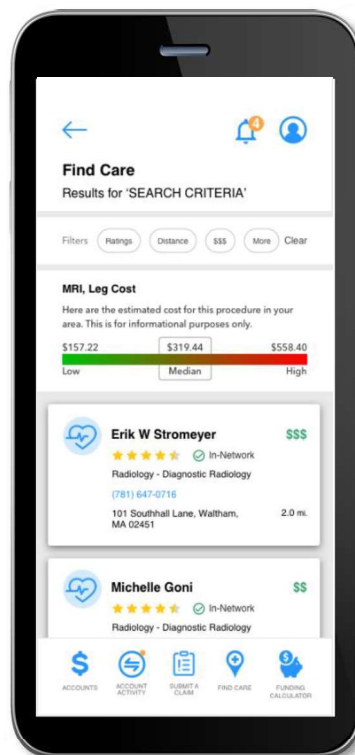
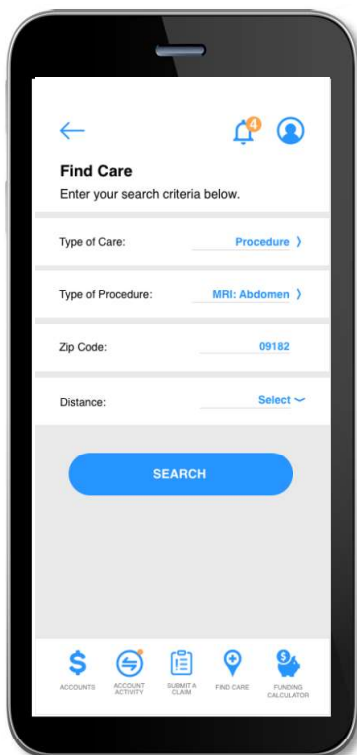
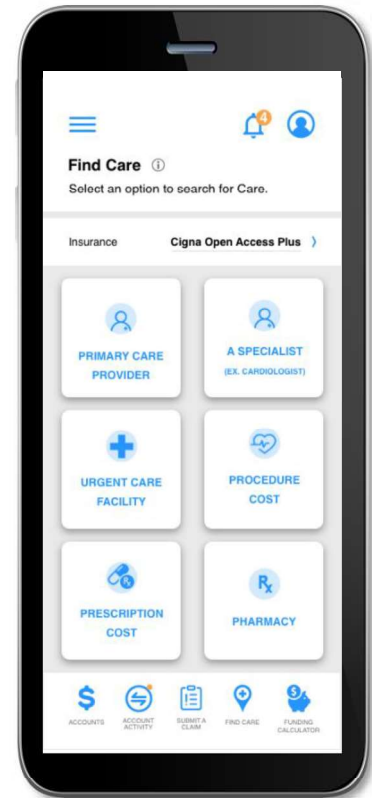


## Find Care

The My SmartCare app includes a *Find Care* feature which can be accessed from the menu or by clicking on the icon at the bottom of most screens found throughout the app.

Find Care allows you to search for care in a few different ways. By adding your insurance carrier, you will only see in-network providers.

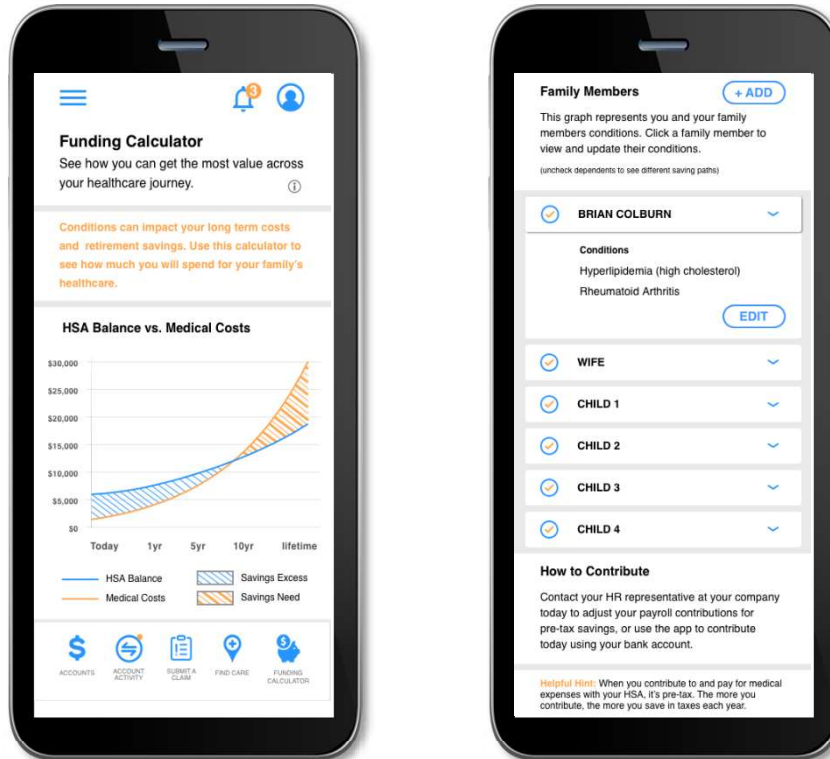
1. If you search for a Primary Care Provider, a Specialist, or an Urgent Care Facility, your results will display with options to filter by patient satisfaction scores and distance
2. If you search for Procedure Cost, the app will return the average cost for the procedure in your area as well as an estimated cost for each provider
3. If you search for a Prescription Cost, the Pharmacies nearby that could fill your prescription along with the associated price will be displayed; you can also search specifically for Pharmacies



After you select one of the types of care, you will be prompted to enter additional information dependent on the type of care selected.

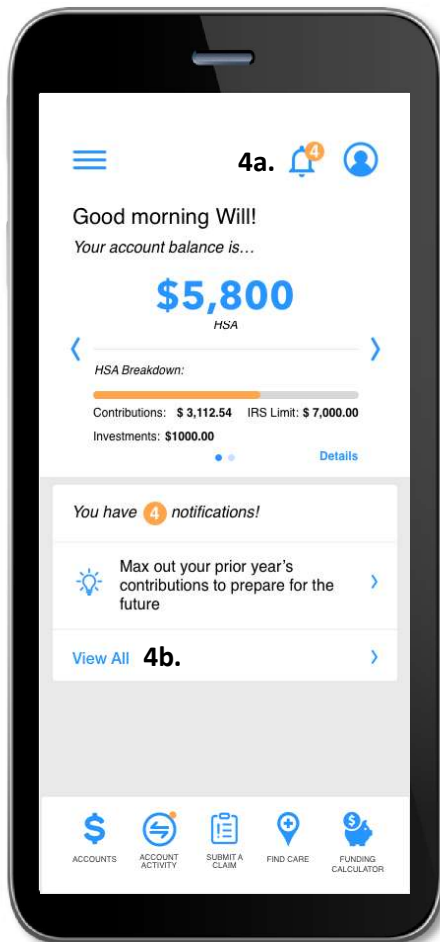
## Funding Calculator

Another My SmartCare app feature is a *Funding Calculator* that considers chronic condition costs in order to help estimate the future value of your health savings account, if applicable. Based upon the conditions you list for yourself and your dependents as well as your HSA contributions, the *Funding Calculator* projects your healthcare costs versus your projected HSA balance.



## Home Screen and Menu

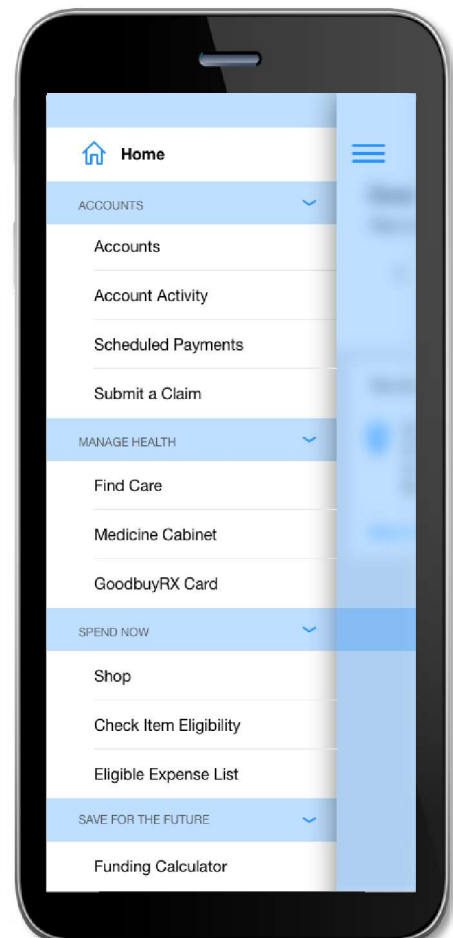
Once you are logged in, you will see the home screen:



1. The Home screen provides an account snapshot with balance breakdown
2. The account carousel allows you to scroll to other accounts you have, if applicable (i.e., scroll from an HSA, to an LPFSA)
3. You can click the “Details” text to go directly to your account page
4. You can navigate to your *Notification Center* by clicking the icon at the top [4a] or by clicking “View All” [4b]

Menu buttons at the bottom of the screen allow you to reach the most commonly used pages with a single tap.

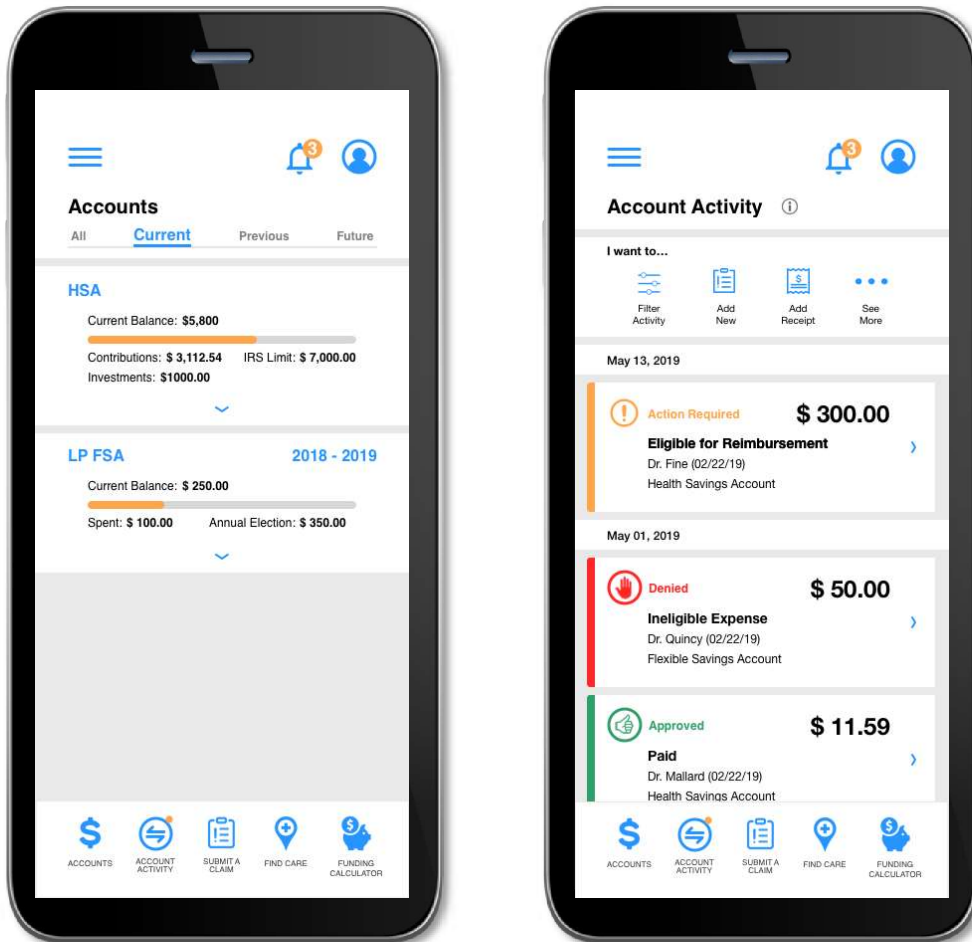
All the menu items found at the bottom of the home screen, plus many other helpful links, can be accessed at any time by tapping the menu symbol found in the upper left corner of every screen in the application.



## Accounts and Account Activity

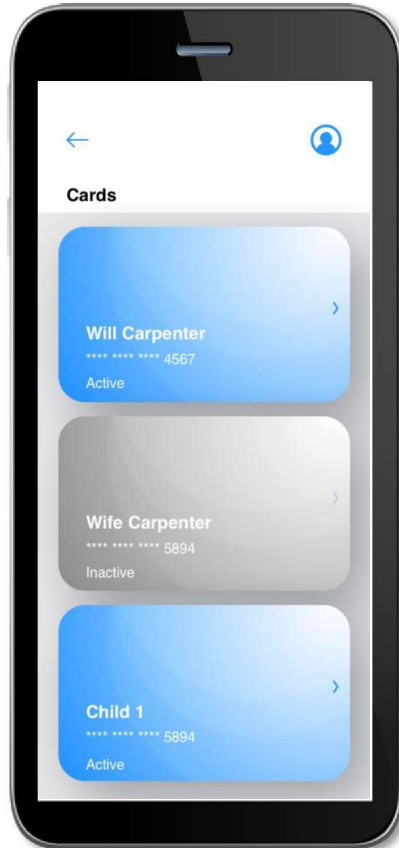
The *Accounts* screen displays a listing of all your benefit account(s) and their balances. This list can be filtered by plan year (current, future, previous, or all) by clicking the related link.

The *Account Activity* section of the app will show you what is approved, pending, and denied as well as what requires an action from you (e.g., adding a receipt). You can filter the results, add receipts, and much more.



## Cards

The *Cards* screen allows you to view all details related to your benefit debit card(s); you may also access the four-digit PIN associated with your card on this screen. Additionally, you can use this section of the app to mark a card lost/stolen or request a new card.

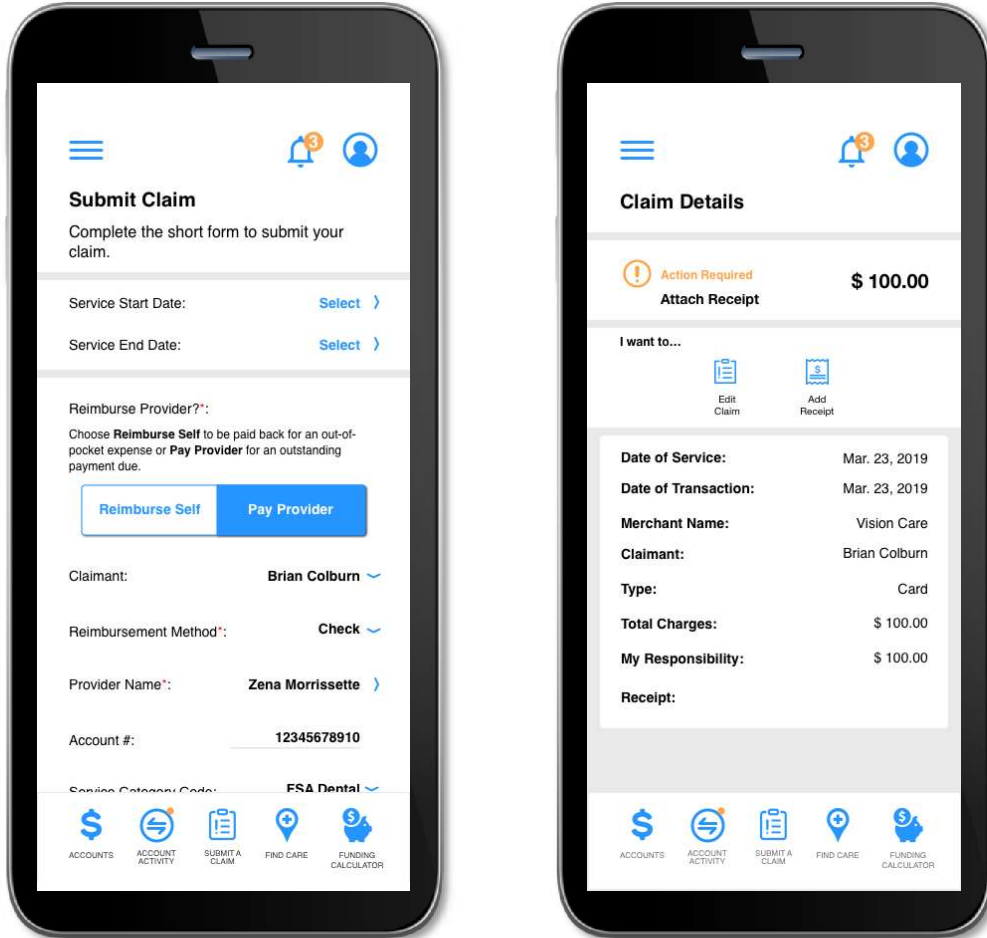


The *Cards* screen displays the cardholder, last four digits of the card number, the card status, and whether the card is associated with a dependent. Tap any individual card on the screen to access the card details.

- View PIN**  
 If you tap the *view PIN* button, an image of the four-digit PIN associated with the selected card displays. You can use this PIN when a card transaction is processed as a debit at the point-of-sale (instead of as a credit, with a signature).
- Mark as lost/stolen**  
 If your card has been lost or stolen, notify your plan administrator by tapping the *Lost/Stolen* button from the *Cards* details screen. You can choose whether you would like to have a new card issued. If your card is marked as lost/stolen, the card status changes accordingly on the *Cards* main screen.
- Activate card**  
 If you have a new card, you may opt to activate your card later or during your current session.

## Claims Submission

The *Submit a Claim* screen allows you to enter new claims and expenses, as well as view and edit pending ones. If you have a receipt to substantiate your claim, you can take a photo of it with your device and attach it to a pending claim from this section of the app.



## Summary Plan Description



# Cottingham & Butler

## Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan

*includes*

Premium Payment  
Medical/Dental Reimbursement Account  
Dependent Care Assistance Plan  
Health Savings Account Option

This booklet is your Summary Plan Description (SPD) for the Flexible Compensation Plan offered by Cottingham & Butler Insurance Services, Inc.. Its purpose is to summarize the provisions of the Plan, which provide and/or affect payment or reimbursement. This SPD supersedes any and all SPDs previously issued to you by Cottingham & Butler Insurance Services, Inc. The Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan Document and any enacted amendments take precedence over this booklet.

All benefits described herein are being provided and maintained for you by Cottingham & Butler Insurance Services, Inc., referred to herein as the “Company.” Self Insured Services Company processes all benefit payments. All claims must be filed in the manner specified by the Company.

A Flexible Compensation Plan allows you to convert a taxable cash benefit (your wages/salary) into non-taxable benefits provided by plans maintained by the Company for 1) Premium Payment for Company-sponsored benefit plans, 2) Medical/Dental Reimbursement, and/or 3) Dependent Care Assistance. There is also an option to have Health Savings Account contributions made on a non-taxable basis. Generally speaking, by participating in this Plan, you are using pre-tax dollars for these benefits and thus lowering your taxable income, which results in more take home pay.

The Plan is intended to qualify as a “cafeteria plan” under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.

*Claims processor:*

**Self Insured Services Company (SISCO)  
P. O. Box 389**

**Dubuque, Iowa 52004-0389  
(563) 583-7344 / (800) 457-4726**

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## **1. FLEXIBLE COMPENSATION PLAN INTRODUCTION**

WHEREAS, Cottingham & Butler Insurance Services, Inc., hereinafter referred to as the "Company," hereby establishes the benefits, rights, and privileges which shall pertain to Participating employees, hereinafter referred to as "Participants."

### **1.1 PURPOSE**

The purpose of this Plan is to provide employees of Cottingham & Butler Insurance Services, Inc., a choice between their cash compensation and optional benefits, as described in 1.3, maintained by Cottingham & Butler Insurance Services, Inc.

### **1.2 EFFECTIVE DATE**

The effective date of the Plan is June 1, 1986, as restated January 1, 2010.

### **1.3 BENEFIT OPTIONS**

A Participant may choose under this Plan to receive his or her full compensation for any Plan Year in cash or to have a portion of it applied by the Company toward the cost of the following optional benefits:

- A. Benefits available to the Participant under the Medical/Dental Reimbursement Plan.
- B. Benefits available to the Participant under the Dependent Care Assistance Plan.
- C. Benefits available to the Participant under the Health Savings Account (HSA) Option.\*

\* Participants who elect the HSA benefit option are not eligible to elect the Medical/Dental Reimbursement Plan option.

### **1.4 DESCRIPTION OF BENEFITS OTHER THAN CASH**

If a Participant elects an optional benefit, the Participant's cash compensation will be reduced, and an amount equal to the reduction will be contributed by the Company under a reimbursement account in accordance with the Dependent Care Assistance Plan or Medical/Dental Reimbursement Plan, as the case may be.

Premium contributions for Company sponsored benefit plans will automatically be taken pre-tax, unless an election is made, in writing, to have premiums taken after tax.

## **2. PARTICIPANT ELIGIBILITY AND TERMINATION**

### **2.1 ELIGIBILITY FOR PARTICIPATION**

Each employee who works for the Company at least 30 hours per week on a regular full-time basis.

### **2.2 EFFECTIVE DATE OF PARTICIPATION**

An eligible employee will become a Participant on the later of (a) the Effective Date of the Plan; or (b) his first day of employment with the Company. If an Employee does not enroll when initially eligible, he may enroll at the time of the annual enrollment period as established by the Company.

### **2.3 IRREVOCABILITY OF ELECTION BY PARTICIPANT DURING THE PLAN YEAR**

Elections made under the Flexible Spending (Section 125) Plan shall be irrevocable by the Participant during the Plan Year, subject to a change in family status. A Participant may revoke a benefit election for the balance of a Plan Year and file a new election only if both the revocation and the new election are on account of and consistent with a change in family status. A change in family status for this purpose includes marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, and such other events that the Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service. All new elections must be made within 31 days of the change in family status. Any new election under this section shall be effective at such time as the Administrator shall prescribe, but no earlier than the first pay period beginning after the election form is completed and returned to the Administrator.

### **2.4 TERMINATION OF PARTICIPATION**

Elections made under this Plan (or deemed to be made under Section 3.3) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although benefits under the Company Sponsored health insurance plan, and the Dependent Care Assistance and/or Medical/Dental Reimbursement Plans may continue if and to the extent provided by such Plans.

A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates; or (b) the date on which he ceases to be an employee; or (c) the date he is no longer eligible to participate under Section 2.1.

The Participant must apply for reimbursement before the earlier of (1) the 180th day following the date the Participant is terminated, and (2) the 90th day after the close of the Plan Year.

### **2.5 REINSTATEMENT OF FORMER PARTICIPANT**

A former Participant will become a Participant again if and when he meets the eligibility requirements of the Plan and upon completion of proper enrollment forms. A Participant whose coverage terminates as a result of a separation from the service of the Company shall not be permitted to make new benefit elections under this Plan upon reemployment during the Plan Year in which such previous coverage terminated. This limitation will not apply to the premium contribution benefit of the Plan.

### **3. ELECTION PROCESS**

#### **3.1 ELECTION PROCEDURE**

Each employee who works for the Company on a regular full-time basis will be eligible to participate in the plan. Approximately 30 days prior to the commencement of each Plan Year, the Administrator shall provide one or more written Election Forms and Compensation Reduction Agreements to each Participant and to each other employee who is eligible to become a Participant at the beginning of the Plan Year. The election forms shall be effective as of the first day of the Plan Year. Each Participant who desires one or more optional benefits for the Plan Year shall so specify on the appropriate election form or forms and shall agree to a reduction in his compensation. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 1.3, shall be the amount elected by the Participant, subject to the limitations of the Dependent Care Assistance Plan and the Medical/Dental Reimbursement Plan. Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the first pay day for which the Participant's Compensation Reduction Agreement will apply.

Health Plan contributions shall be automatically taken on a pre-tax basis unless the Employee elects out of the Health Plan contribution benefit. The amount of the reduction in the Participant's compensation for the Plan Year for a Company Sponsored benefit plan shall equal the Participant's share of the cost of the benefits and shall be adjusted automatically in the event of a change in any such cost.

#### **3.2 NEW EMPLOYEES**

As soon as practicable before an employee becomes a Participant, the Administrator shall provide the written Election Forms and Compensation Reduction Agreements to the employee. If the employee desires one or more optional benefits for the balance of the Plan Year, he shall so specify on the election forms and shall agree to a reduction in his compensation. The election forms must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Compensation Reduction Agreements will apply.

Company sponsored benefit Plan premium contributions shall be automatically taken on a pre-tax basis unless the Employee makes a written election to have premiums taken after tax.

#### **3.3 FAILURE TO ELECT**

A Participant failing to return a completed Election Form to the Administrator on or before the specified due date for the initial Plan Year of the Plan, or for the Plan Year in which he became a Participant, shall be deemed to have elected to receive his full compensation in cash. A Participant failing to return a completed election form to the Administrator relating to the optional benefits on or before the specified due date for any subsequent Plan Year shall be deemed to have elected cash compensation in lieu of such optional benefit, regardless of the election in effect during the preceding Plan Year.

Company sponsored benefit Plan premium contributions shall be automatically taken on a pre-tax basis unless the Employee makes a written election to have premiums taken after tax. This election will continue form year to year unless the Employee opts out in writing.

## **4. PREMIUMS FOR COTTINGHAM & BUTLER INSURANCE SERVICES, INC. SPONSORED PLANS**

### **4.1 CONTRIBUTIONS FOR PREMIUMS**

For purposes of any Company sponsored benefit Plan, offered under this Plan, an eligible Employee who is a participant in any Company sponsored benefit Plan will be deemed to be a Participant in this Plan and be deemed to have consented to a reduction in the Employee's compensation to permit contributions for any Company sponsored benefit Plan premium to be taken on a pre-tax basis. An eligible Employee may elect to have contributions for any Company sponsored benefit Plan taken after taxes by making an affirmative election not to participate when completing the enrollment paperwork for the Plan.

### **4.2 RIGHT OF COMPANY TO SUBSTITUTE PROVIDERS OR OPTIONS UNDER THE PLAN**

Cottingham & Butler Insurance Services, Inc. reserves the right to delete or substitute any provider or option, for the Company sponsored benefit plans at any time and without any further obligation to the Employees. Any affected Employee shall continue his election as modified. If any option is deleted, upon the next Plan anniversary date, any affected Employee may elect any option under the Plan and may be eligible for, or elect not to have such coverage under any option, to incur no salary reduction, and instead to receive his pay without such reduction.

## **5. MEDICAL/DENTAL REIMBURSEMENT ACCOUNTS**

### **5.1 ESTABLISHMENT OF ACCOUNTS**

The Company will establish and maintain on its books a Medical/Dental Reimbursement Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical/Dental Care Expenses incurred during the Plan Year.

The Medical/Dental Care Reimbursement Account benefit option is not available to individuals who have a Health Savings Account (HSA).

### **5.2 CREDITING OF ACCOUNTS**

There shall be credited to a Participant's Medical/Dental Reimbursement Account for each Plan Year, as of each date compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such compensation in accordance with the Participant's election and compensation reduction agreement under the Flexible Spending Plan. All amounts credited to each such Medical/Dental Reimbursement Account shall be the property of the Company until paid out pursuant to the payment provisions of this Plan.

### **5.3 DEBITING OF ACCOUNTS**

A Participant's Medical/Dental Reimbursement Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Medical/Dental Care Services incurred during such Plan Year. Amounts debited to each such Medical/Dental Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

The maximum amount of reimbursement, minus any previous reimbursements, must be available throughout the Plan Year.

### **5.4 CLAIMS FOR REIMBURSEMENT**

A Participant who has elected to receive medical/dental care reimbursement for a Plan Year may apply to the Company for reimbursement of qualifying medical/dental expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Company in such form as the Company may prescribe, setting forth:

- A. The amount, date, and nature of the expense with respect to which a benefit is requested;
- B. The name of the person for whom the expense was incurred;
- C. A receipt or bill from the person or entity with whom the expense was incurred; and
- D. Such other information as the Company may from time to time require.

## **5.5 REIMBURSEMENT OR PAYMENT OF EXPENSES**

The Company shall reimburse the Participant from the Participant's Medical/Dental Reimbursement Account for Qualifying Medical Care Expenses incurred (medical/dental service is actually rendered) during the Plan Year for which the Participant submits in the form prescribed by the Company under Section 5.4. No reimbursement or payment of expenses incurred during a Plan Year shall at any time exceed the Participant's Medical/Dental Reimbursement Election for the Plan Year. The amount of any Qualifying Medical Care Expenses not reimbursed or paid as a result of the preceding sentence shall not be carried over to the following Plan Year.

## **5.6 FORFEITURE OF ACCOUNTS**

The amount credited to a Participant's Medical/Dental Reimbursement Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during such Plan Year and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant's Medical/Dental Reimbursement Account for any Plan Year after all reimbursements hereunder, such balance shall not be available to the Participant in any other form or manner, and will remain the property of the Company. However, an amount of up to \$500 of unused Medical/Dental Reimbursement Account funds may be carried over to the following Plan Year for expenses incurred during that Plan Year. For example, at the end of 2014, after all expenses for that year have been reimbursed, your account has a balance of up to \$500, that amount will carry over to be used for eligible expenses incurred in 2015. This carry over provision will continue from year to year with the maximum carryover of \$500. This carryover amount will not decrease the maximum contribution that the Plan allows.

## **5.7 [THIS PROVISION DELETED BY AMENDMENT.]**

## **5.8 MEDICAL/DENTAL REIMBURSEMENT ACCOUNT DISTRIBUTION FOR MEMBERS OF THE ARMED FORCES RESERVE**

A member of the Armed Forces reserve component who is ordered or called to active duty for a period of 180 days or longer may withdraw unused amounts in his health flexible spending account. The distribution will be subject to employment taxes and included in the employee's gross income on his W-2 for the year in which the withdrawal is made. Request for the withdrawal must be made beginning with the date of the order or call to active duty and ending on the last day of the Plan Year in which the employee was called to active duty. The employee will be eligible to withdraw the amount contributed to the Medical/Dental Reimbursement Account as of the date he terminates coverage under the Plan, minus any Medical/Dental reimbursements received as of that date.

## **5.9 MAXIMUM MEDICAL/DENTAL REIMBURSEMENT ACCOUNT CONTRIBUTION**

During a Plan Year, the maximum amount a Participant may contribute to the Medical/Dental Reimbursement Account is based on the amount allowed by the IRS.

## **6. DEPENDENT CARE ASSISTANCE ACCOUNTS**

### **6.1 ESTABLISHMENT OF ACCOUNTS**

The Company will establish and maintain on its books a Dependent Care Assistance Account for each Plan Year with respect to each Participant who has elected to receive dependent care assistance for the Plan Year.

### **6.2 CREDITING OF ACCOUNTS**

There shall be credited to a Participant's Dependent Care Assistance Account for each Plan Year, as of each date compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such compensation in accordance with the Participant's election and compensation reduction agreement under the Flexible Spending Plan. All amounts credited to each such Dependent Care Assistance Account shall be the property of the Company until paid out pursuant to the payment provisions of this Plan.

### **6.3 DEBITING OF ACCOUNTS**

A Participant's Dependent Care Assistance Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year. Amounts debited to each such Dependent Care Assistance Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

### **6.4 MAXIMUM DEPENDENT CARE ASSISTANCE**

The maximum amount which the Participant may receive in any Plan Year in the form of dependent care assistance under this Plan shall be the least of (a) the Participant's earned income for the Plan Year (after all reductions in compensation including the reduction related to dependent care assistance), or (b) the actual or deemed earned income of the Participant's spouse for the Plan Year. In addition, for any taxable year, the Participant may not receive more than the amount excludable with respect to such Participant under Internal Revenue Code Section 129(a) for the year in which dependent care assistance payments hereunder are made. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself, such spouse shall be deemed to have earned income of not less than \$200 per month if the Participant has one Dependent, and \$400 per month if the Participant has two or more Dependents. Charges are allowable only for dependent children under the age of thirteen (13), handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return.

To be eligible for Dependent Care Reimbursement, both spouses must be working or actively seeking work unless one is disabled or a full-time student. Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19) or a non-relative, as long as such person is reporting payments as income, is also eligible.

## **6.5 CLAIMS FOR REIMBURSEMENT**

A Participant who has elected to receive dependent care reimbursement for a Plan Year may apply to the Company for reimbursement of qualifying dependent expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Company in such form as the Company may prescribe setting forth:

- A. The amount, date, and nature of the expense with respect to which a benefit is requested;
- B. The name of the person for whom the expense was incurred;
- C. A receipt or bill from the person or entity with whom the expense was incurred; and
- D. Such other information as the Company may from time to time require.

The Company shall reimburse the Participant from the Participant's Dependent Care Assistance Account for Dependent Care Expenses incurred during the Plan Year for which the Participant submits in the form prescribed by the Company. *No reimbursement or payment of expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Dependent Care Assistance Account at the time of the reimbursement or payment.* The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence shall be carried over and reimbursed or paid only if and when the balance in such Account permits such reimbursement or payment. No amount of non-reimbursed expenses shall be allowed to be carried forward to the subsequent Plan Year.

## **6.6 FORFEITURE OF ACCOUNTS**

The amount credited to a Participant's Dependent Care Assistance Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year, and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant's Dependent Care Assistance Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the Company, and the Participant shall forfeit all rights with respect to such balance.

## **6.7 [THIS PROVISION DELETED BY AMENDMENT.]**

## **7. RIGHTS UNDER ERISA**

### **7.1 Your Rights**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:

#### **7.2 Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

#### **7.3 Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

#### **7.4 Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order

you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **7.5 Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **8. PLAN ADMINISTRATION**

### **8.1 CAFETERIA PLAN STATUS**

This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.

### **8.2 NAMED FIDUCIARY AND PLAN ADMINSTRATOR**

The Named Fiduciary and Plan Administrator is Cottingham & Butler Insurance Services, Inc. who shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Company shall have the authority to amend the Plan, to determine its policies, to appoint and remove persons or entities to be responsible for administering any aspects of the Plan, fix their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

### **8.3 PLAN IS NOT A CONTRACT**

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Participant of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

### **8.4 LIMITATION OF RIGHTS**

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving any Participant or other person any legal or equitable right against the Company, except as provided herein.

### **8.5 CONFORMITY WITH GOVERNING LAW**

To the extent not preempted by ERISA, this Plan shall be construed, administered, and enforced according to the laws of the State of Iowa. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

### **8.6 INDEMNIFICATION OF ADMINISTRATOR**

The Company agrees to indemnify and to defend to the fullest extent permitted by law any employee serving as the Administrator or as a member of a committee designated as Administrator (including any employee or former employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

## **8.7 NONDISCRIMINATORY EXERCISE OF AUTHORITY**

Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

## **8.8 ADMINISTRATIVE POWERS AND DUTIES OF THE PLAN ADMINISTRATOR AND CLAIMS PROCESSOR**

The Plan Administrator and the claims processor shall have the following administrative responsibilities and authority with respect to the Plan:

1. Make such uniform and non-discriminatory rules and regulations for the administration and interpretation of the Plan as are consistent with the terms hereof or of applicable laws.
2. Establish and maintain records appropriate to permit the Plan to be administered according to its terms and requirements of applicable laws.
3. Prepare and file or otherwise disseminate all reports, filings and documents required by applicable laws or regulations.
4. With the advance approval of the Plan Administrator, the claims processor may employ one or more persons, including an enrolled actuary, an independent qualified public accountant, and/or counsel, to perform such duties as may from time to time be required and to render advice upon request with regard to any matters arising under the Plan.
5. Interpret the Plan and decide any matters arising hereunder in the administration and operation of the plan, and any interpretations or decisions so made will be conclusive and binding on all persons having an interest in the Plan; provided, however, that all such interpretations and decisions shall be applied in a uniform manner to all Employees similarly situated.
6. Establish in writing a claims procedure in accordance with the appropriate plan documents (as modified by this Plan) which provide the benefits, and in accordance with regulations of the Secretary of Labor.
7. Take all other steps deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable laws.

## **8.9 EXAMINATION OF RECORDS**

The Administrator will make available to each Participant such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

## **8.10 RELIANCE ON TABLES, ETC.**

In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the administrators of the Dependent Care Assistance and Medical/Dental Reimbursement Plans, or by accountants, counsel, or other experts employed or engaged by the Administrator.

### **8.11 CLAIMS DENIAL AND REVIEW PROCEDURE**

All claims must be filed with the Plan within 90 days following the end of the Plan Year. If any such claim is wholly or partially denied, the Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary for such person to perfect such claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if the person wishes to submit a request for review. Such notification will be given within 30 days after the claim is received by the Administrator (or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and such person may request a review of his claim.

Within 180 days after the date on which a person receives a written notice of a denied claim (or, if applicable, within 180 days after the date on which such denial is considered to have occurred) such person (or his duly authorized representative) may (i) file a written request with the Administrator for a review of his denied claims and of pertinent documents, and (ii) submit written issues and comments to the Administrator. The Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain specific reasons for the decisions as well as specific references to pertinent Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Administrator to hold a hearing, and if written notice of such extension and circumstance is given to such person within the initial 60 day period).

### **8.12 REPORT TO PARTICIPANTS ON OR BEFORE JANUARY 31 OF EACH YEAR**

On or before January 31 of each year, the Administrator shall furnish to each Participant who has received dependent care assistance during the prior calendar year a written statement showing the amount of such reimbursements received during such year with respect to the Participant.

### **8.13 PERMITTED AND REQUIRED USES OF PROTECTED HEALTH INFORMATION**

Protected Health Information (PHI) is individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium. PHI will only be released to the "Privacy Officials" appointed by the Company. A list of Privacy Officials may be obtained from the Company.

Your health Plan will only provide Protected Health Information to the Plan Sponsor upon receipt of certification that the Plan Sponsor will agree to:

1. Not use or disclose the PHI other than as permitted or required by the Plan Document or as required by law;
2. Ensure that agents and subcontractors to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions as the Plan Sponsor;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the group health Plan any PHI use or disclosure, of which it becomes aware, that violates the permitted uses or disclosures under HIPAA;
5. Make PHI available in accordance with HIPAA Access Requirements;
6. Make PHI available for amendment and incorporate those amendments as required by the privacy regulations;
7. Make information available to provide an accounting of disclosures as provided in the privacy regulations;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of the Department of Health and Human Services;
9. If feasible, at termination of the relationship, return or destroy all PHI received from the group health plan, but if return or destruction is not feasible, limit further uses or disclosures to those purposes that make return or destruction of the information infeasible; and
10. Ensure adequate separation between employees who are authorized to use PHI and those who are not.

Any information supplied to the Plan Sponsor in order to process claims and claim payment will be kept confidential by all individuals within the Company who use this information in the normal course of business. These individuals will restrict access to and use of PHI by individuals other than for plan administration functions that the Plan Sponsor performs for the group health plan. Misuse or disclosure of PHI by any individual in the Company may result in disciplinary sanctions, such as dismissal. The Company shall provide a mechanism for resolving issues of noncompliance. PHI will not be disclosed to a Plan Sponsor for employment-related activities or decisions or in connection with any other benefit plan of the Plan Sponsor.

#### **8.14 HIPAA SECURITY PROVISION**

Where electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. sect. 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and

4. Plan Sponsor shall report to the Plan any “Security Incidents” of which it becomes aware as described below (“Security Incidents” has the meaning set forth in 45 C.F.R. sect. 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system):
  - a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any “Security Incident” that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s electronic Protected Health Information; and
  - b) Plan Sponsor shall report to the Plan any other “Security Incident” on an aggregate basis every quarter, or more frequently upon the Plan’s request.

## **9. AMENDMENTS TO OR TERMINATION OF THE PLAN**

### **9.1 PLAN AMENDMENTS**

This document contains all the terms of the Plan and may be amended from time to time by the Company. Any changes so made shall be binding on each Covered Participant and on any other Covered Persons referred to in this Plan Document.

### **9.2 CHANGES BY ADMINISTRATOR**

If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated employees or Key Employees with or without the consent of such employee.

### **9.3 TERMINATION OF PLAN**

The Company reserves the right at any time to terminate the Plan by a written instrument to that effect. Claims arising prior to the effective date of termination will be paid if proof of such claims is submitted to the Plan Administrator in accordance with the Dependent Care Assistance Plan and the Medical/Dental Reimbursement Plan. Such claims must be submitted on or before the 90th day following the effective date of the Plan termination.

## **10. MISCELLANEOUS**

### **10.1 RIGHTS OF EMPLOYEES**

Nothing herein contained shall be deemed to give any Employee the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge such Employee at any time, nor shall it be deemed to give the Company the right to require the Employee to remain in its employ, nor shall it interfere with the Employee's right to terminate his employment at any time.

### **10.2 NOTICE OF ADDRESS**

Each person entitled to benefits under the Plan must file with the Plan Administrator, in writing, his post office address and each change of post office address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the plan, and there shall be no obligation on the part of the Plan Administrator and the claims processor to search for or to ascertain the location of such person.

### **10.3 DATA**

Each person entitled to benefits under the Plan must furnish to the Plan Administrator and the claims processor such documents, evidence, or other information as considered necessary or desirable for the purposes of administering the Plan or to protect the Plan. The Plan Administrator and the claims processor shall be entitled to rely on representations made by Employees, with respect to age, marital status and other personal facts, unless it knows said representations are false.

### **10.4 HEADINGS**

The headings of the Plan are inserted for convenience and reference and shall have no effect upon the meaning of the provisions hereof.

### **10.5 CONSTRUCTION**

The Plan shall be construed, regulated and administered under the laws of Iowa, except that if any such laws are superseded by any applicable Federal law or statute, such Federal law or statute shall apply.

## **11. DEFINITIONS**

### **11.1 CODE**

The term "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

### **11.2 COMPANY**

The term "Company" means Cottingham & Butler Insurance Services, Inc.

### **11.3 DEPENDENT**

The term "Dependent" means any person who falls within the definition of dependent provided in Section 105(b) of the Code.

### **11.4 DEPENDENT CARE ASSISTANCE PLAN**

The term "Dependent Care Assistance Plan" means the Cottingham & Butler Insurance Services, Inc. Dependent Care Assistance Plan as amended from time to time.

### **11.5 EMPLOYEE**

The term "employee" means any individual employed by Cottingham & Butler Insurance Services, Inc.

### **11.6 EMPLOYMENT**

The term "employment" means a basis whereby a Participant is employed by the Company. Such work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Participant to travel, and for which he receives regular earnings from the Company.

### **11.7 ERISA**

The term "ERISA" means the Employee Retirement Income Security Act of 1974, and as amended from time to time.

### **11.8 KEY EMPLOYEE**

The term "Key Employee" means any person who is a Key Employee as defined in Section 416(i)(1) of the Code.

### **11.9 MEDICAL/DENTAL REIMBURSEMENT PLAN**

The term "Medical/Dental Reimbursement Plan" means the Cottingham & Butler Insurance Services, Inc. Medical/Dental Reimbursement Plan as amended from time to time.

### **11.10 PARTICIPANT**

The term "Participant" means any individual who participates in the Plan in accordance with the provisions of Article 3.

### **11.11 PLAN**

The term "Plan" means the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan, as set forth herein, together with any and all amendments and supplements hereto.

### **11.12 PLAN ADMINISTRATOR**

The term "Plan Administrator" means the Company or such other person or committee as may be appointed from time to time by the Company to supervise the administration of the Plan.

### **11.13 PLAN SPONSOR**

The term "Plan Sponsor" means Cottingham & Butler Insurance Services, Inc.

### **11.14 PLAN YEAR**

The term "Plan Year" means the period beginning on January 1<sup>st</sup> through December 31<sup>st</sup>. In the event a Participant commences participation during a Plan Year, the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

### **11.15 QUALIFYING MEDICAL CARE EXPENSE**

The term "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 paid for hospital bills, doctor and dental bills, and drugs) with the exception of premiums for coverage, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under the Plan).

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

## **ADDENDUM: HEALTH SAVINGS ACCOUNT OPTION**

A Health Savings Account (HSA) is an account established under Section 223 for the purpose of paying qualified medical expenses. An eligible Employee can elect to participate in this Plan's HSA benefit option by electing (a) to enroll and be covered by the qualifying high deductible health plan (HDHP) offered by the Company (and does not have disqualifying coverage under another health plan, including Medicare); (b) to set up a tax-exempt trust or custodial account with a qualified-HSA trustee to pay or reimburse certain allowed medical expenses that the Participant and any qualified Dependents incur; and (c) to make contributions to such HSA on a pre-tax salary basis. All contributions to an HSA are subject to any applicable federal and/or state regulations, which may vary from the other options offered under this Flexible Compensation Plan.

The maximum dollar amount that a Participant may contribute to a HSA is set by federal statute and IRS regulations. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the HDHP coverage option (i.e., single or family) for the Plan Year in which the contribution is made. Also, in the event the Employer provides contributions to the Employee's HSA, the combined total of Employer and Participant contributions must not exceed the maximum amount allowed by the IRS. When a Participant ceases to be a Participant, the Participant's salary reductions will terminate.

A Participant may make changes in their election prospectively, effective on the first day of the first payroll period in any month, regardless of whether or not the Participant can show a change in status, subject to the statutory maximum amount. Changes in contributions to an HSA that are made due to a change in status (e.g., changing from family coverage to single coverage) are also subject to the IRS Full Contribution Rule.

The HSA benefit option under this Plan consists solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis. The HSA benefit option is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2).

The Company has no authority or control over the funds deposited in a HSA. Even though this Plan option may allow pre-tax salary reduction contributions to an HSA, the HSA benefit option is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

An eligible Employee electing to participate in this HSA option cannot also elect the Medical/Dental Care Reimbursement Account benefit option.

## SIXTH AMENDMENT – Flexible Compensation Plan

WHEREAS, on June 1, 1986, as restated January 1, 2010, Cottingham & Butler Insurance Services, Inc. established the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan for all eligible employees of Cottingham & Butler Insurance Services, Inc.; and

WHEREAS, said Plan Document provides that Cottingham & Butler Insurance Services, Inc. may amend the Plan without the consent of any covered individual; and

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE, it is resolved that the Plan is amended in the following particulars:

### Effective January 1, 2019

- 1) Page 1, “1.3 Benefit Options” shall be deleted and replaced with the following:

#### **“1.3 BENEFIT OPTIONS**

A Participant may choose under this Plan to receive his or her full compensation for any Plan Year in cash or to have a portion of it applied by the Company toward the cost of the following optional benefits:

- A. Benefits available to the Participant under the Medical/Dental Reimbursement Plan.
- B. Benefits available to the Participant under the Dependent Care Assistance Plan.
- C. Benefits available to the Participant under the Health Savings Account (HSA) Option.\*

\* Participants who elect the HSA benefit option are not eligible to elect the Medical/Dental Reimbursement Plan option.”

- 2) Page 5, the following shall be added to “5.1 Establishment of Accounts”:

“The Medical/Dental Care Reimbursement Account benefit option is not available to individuals who have a Health Savings Account (HSA).”

- 3) The following shall be added as an addendum to the Plan:

#### **“ADDENDUM: HEALTH SAVINGS ACCOUNT OPTION**

A Health Savings Account (HSA) is an account established under Section 223 for the purpose of paying qualified medical expenses. An eligible Employee can elect to participate in this Plan’s HSA benefit option by electing (a) to enroll and be covered by the qualifying high deductible health plan (HDHP) offered by the Company (and does not have disqualifying coverage under another health plan, including Medicare); (b) to set up a tax-exempt trust or custodial account with a qualified-HSA trustee to pay or reimburse certain allowed medical expenses that the Participant and any qualified Dependents incur; and (c) to make contributions to such HSA on a pre-tax salary basis. All contributions to an HSA are subject to any applicable federal and/or state regulations, which may vary from the other options offered under this Flexible Compensation Plan.

Cottingham & Butler Insurance Services, Inc.  
SIXTH AMENDMENT – Flexible Compensation Plan

The maximum dollar amount that a Participant may contribute to a HSA is set by federal statute and IRS regulations. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the HDHP coverage option (i.e., single or family) for the Plan Year in which the contribution is made. Also, in the event the Employer provides contributions to the Employee's HSA, the combined total of Employer and Participant contributions must not exceed the maximum amount allowed by the IRS. When an Participant ceases to be a Participant, the Participant's salary reductions will terminate.


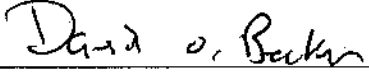
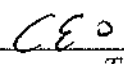
A Participant may make changes in their election prospectively, effective on the first day of the first payroll period in any month, regardless of whether or not the Participant can show a change in status, subject to the statutory maximum amount. Changes in contributions to an HSA that are made due to a change in status (e.g., changing from family coverage to single coverage) are also subject to the IRS Full Contribution Rule.

The HSA benefit option under this Plan consists solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis. The HSA benefit option is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Company has no authority or control over the funds deposited in a HSA. Even though this Plan option may allow pre-tax salary reduction contributions to an HSA, the HSA benefit option is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

An eligible Employee electing to participate in this HSA option cannot also elect the Medical/Dental Care Reimbursement Account benefit option."

Accepted and Approved this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**Cottingham & Butler Insurance Services, Inc.**

By:   
\_\_\_\_\_  
*Signature of Authorized Representative*  
  
\_\_\_\_\_  
*Print Name*  
  
\_\_\_\_\_  
*Title*

Witnessed By: \_\_\_\_\_  
\_\_\_\_\_  
*Signature of Witness*  
\_\_\_\_\_  
*Print Name*

FIFTH AMENDMENT

WHEREAS, on June 1, 1986, as restated January 1, 2010, Cottingham & Butler Insurance Services, Inc. established the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan for all eligible employees of the Company; and

WHEREAS, said Plan Document provides that the Company may amend the Plan without the consent of or notice to any covered individual; and

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE, effective January 1, 2017, it is resolved that the Plan is amended in the following particulars:

- 1) Page 2, "2.1 Eligibility For Participation" shall be deleted and replaced as follows:

**"2.1 ELIGIBILITY FOR PARTICIPATION**

Each employee who works for the Company at least 30 hours per week on a regular full-time basis."

Dated this 10 day of January 2017.

ACCEPTED AND APPROVED

COTTINGHAM & BUTLER INSURANCE SERVICES, INC.

By: Julia [Signature]

WITNESSED:

By: Jennifer Wolf

FOURTH AMENDMENT

WHEREAS, on June 1, 1986, as restated January 1, 2010, Cottingham & Butler Insurance Services, Inc. established the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan for all eligible employees of the Company; and

WHEREAS, said Plan Document provides that the Company may amend the Plan without the consent of or notice to any covered individual; and

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE, effective January 1, 2015, it is resolved that the Plan is amended in the following particulars:

- 1) Page 6, "5.9 Maximum Medical/Dental Reimbursement Account Contribution" shall be added as follows:

"5.9 MAXIMUM MEDICAL/DENTAL REIMBURSEMENT ACCOUNT CONTRIBUTION

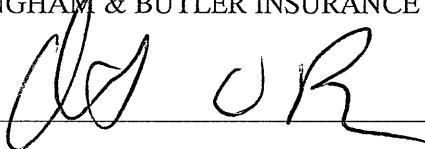
During a plan Year, the maximum amount a Participant may contribute to the Medical/Dental Reimbursement Account is based on the amount allowed by the IRS."

Dated this 24 day of November, 2014

ACCEPTED AND APPROVED

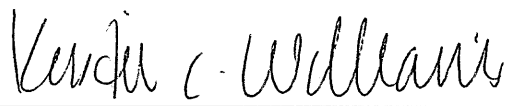
COTTINGHAM & BUTLER INSURANCE SERVICES, INC.

By: \_\_\_\_\_



WITNESSED:

By: \_\_\_\_\_



THIRD AMENDMENT

WHEREAS, on June 1, 1986, as restated January 1, 2010, Cottingham & Butler Insurance Services, Inc. established the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan for all eligible employees of the Company; and

WHEREAS, said Plan Document provides that the Company may amend the Plan without the consent of or notice to any covered individual; and

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE, effective January 1, 2014, it is resolved that the Plan is amended in the following particulars:

- 1) Page 6, "5.7 Grace Period" and all references to it under the "Medical/Dental Reimbursement Accounts" shall be deleted and "Forfeiture of Accounts" shall be replaced as follows:

**"5.6 FORFEITURE OF ACCOUNTS**

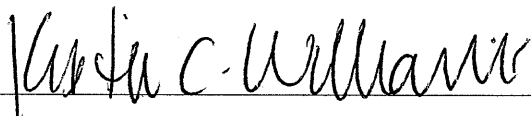
The amount credited to a Participant's Medical/Dental Reimbursement Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during such Plan Year and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant's Medical/Dental Reimbursement Account for any Plan Year after all reimbursements hereunder, such balance shall not be available to the Participant in any other form or manner, and will remain the property of the Company. However, an amount of up to \$500 of unused Medical/Dental Reimbursement Account funds may be carried over to the following Plan Year for expenses incurred during that Plan Year. For example, at the end of 2014, after all expenses for that year have been reimbursed, your account has a balance of up to \$500, that amount will carry over to be used for eligible expenses incurred in 2015. This carry over provision will continue from year to year with the maximum carryover of \$500. This carryover amount will not decrease the maximum contribution that the Plan allows."

- 2) Page 8, "6.7 Grace Period" and all references to it under "Dependent Care Assistance Accounts" shall be deleted.

Dated this 6 day of January, 2014.

ACCEPTED AND APPROVED

COTTINGHAM & BUTLER INSURANCE SERVICES, INC.

By: 

WITNESSED:

By: \_\_\_\_\_

SECOND AMENDMENT

WHEREAS, on June 1, 1986, as restated January 1, 2010, Cottingham & Butler Insurance Services, Inc. established the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan for all eligible employees of the Company; and

WHEREAS, said Plan Document provides that the Company may amend the Plan without the consent of or notice to any covered individual; and

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE, effective January 1, 2013, it is resolved that the Plan is amended in the following particulars:

- 1) Page 6, "5.9 Maximum Medical/Dental Reimbursement Account Contribution" shall be added as follows:

**"5.9 MAXIMUM MEDICAL/DENTAL REIMBURSEMENT ACCOUNT CONTRIBUTION**

During a plan Year, the maximum amount a Participant may contribute to the Medical/Dental Reimbursement Account is \$2,500."

Dated this 9<sup>th</sup> day of January, 2013.

ACCEPTED AND APPROVED

COTTINGHAM & BUTLER INSURANCE SERVICES, INC.

By:  \_\_\_\_\_

WITNESSED:

By: \_\_\_\_\_

FIRST AMENDMENT

WHEREAS, on June 1, 1986, as restated January 1, 2010, Cottingham & Butler Insurance Services, Inc. established the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan for all eligible employees of the Company; and

WHEREAS, said Plan Document provides that the Company may amend the Plan without the consent of or notice to any covered individual; and

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE, effective January 1, 2011, it is resolved that the Plan is amended in the following particulars:

- 1) Page 18, the definition of "Dependent" shall be deleted and replaced as follows:

"11.3 DEPENDENT

The term "Dependent" means any person who falls within the definition of dependent provided in Section 105(b) of the Code."

Dated this 2<sup>nd</sup> day of February, 20 11.

ACCEPTED AND APPROVED

COTTINGHAM & BUTLER INSURANCE SERVICES, INC.

By:  \_\_\_\_\_

WITNESSED:

By: \_\_\_\_\_

**COTTINGHAM & BUTLER INSURANCE SERVICES, INC.**

**Flexible Compensation Plan #501**

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**1. FLEXIBLE COMPENSATION PLAN INTRODUCTION**

WHEREAS, Cottingham & Butler Insurance Services, Inc., hereinafter referred to as the "Company," hereby establishes the benefits, rights, and privileges which shall pertain to Participating employees, hereinafter referred to as "Participants."

**1.1 PURPOSE**

The purpose of this Plan is to provide employees of Cottingham & Butler Insurance Services, Inc., a choice between their cash compensation and optional benefits, as described in 1.3, maintained by Cottingham & Butler Insurance Services, Inc.

**1.2 EFFECTIVE DATE**

The effective date of the Plan is June 1, 1986, as restated January 1, 2010.

**1.3 BENEFIT OPTIONS**

A Participant may choose under this Plan to receive his full compensation for any Plan Year in cash or to have a portion of it applied by the Company toward the cost of one or both of the following optional benefits:

- A. Benefits available to the Participant under the Medical/Dental Reimbursement Plan; and/or
- B. Benefits available to the Participant under the Dependent Care Assistance Plan.

**1.4 DESCRIPTION OF BENEFITS OTHER THAN CASH**

If a Participant elects an optional benefit, the Participant's cash compensation will be reduced, and an amount equal to the reduction will be contributed by the Company under a reimbursement account in accordance with the Dependent Care Assistance Plan or Medical/Dental Reimbursement Plan, as the case may be.

Premium contributions for Company sponsored benefit plans will automatically be taken pre-tax, unless an election is made, in writing, to have premiums taken after tax.

## **2. PARTICIPANT ELIGIBILITY AND TERMINATION**

### **2.1 ELIGIBILITY FOR PARTICIPATION**

Each employee who works for the Company at least 32 hours per week on a regular full-time basis.

### **2.2 EFFECTIVE DATE OF PARTICIPATION**

An eligible employee will become a Participant on the later of (a) the Effective Date of the Plan; or (b) his first day of employment with the Company. If an Employee does not enroll when initially eligible, he may enroll at the time of the annual enrollment period as established by the Company.

### **2.3 IRREVOCABILITY OF ELECTION BY PARTICIPANT DURING THE PLAN YEAR**

Elections made under the Flexible Spending (Section 125) Plan shall be irrevocable by the Participant during the Plan Year, subject to a change in family status. A Participant may revoke a benefit election for the balance of a Plan Year and file a new election only if both the revocation and the new election are on account of and consistent with a change in family status. A change in family status for this purpose includes marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, and such other events that the Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service. All new elections must be made within 31 days of the change in family status. Any new election under this section shall be effective at such time as the Administrator shall prescribe, but no earlier than the first pay period beginning after the election form is completed and returned to the Administrator.

### **2.4 TERMINATION OF PARTICIPATION**

Elections made under this Plan (or deemed to be made under Section 3.3) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although benefits under the Company Sponsored health insurance plan, and the Dependent Care Assistance and/or Medical/Dental Reimbursement Plans may continue if and to the extent provided by such Plans.

A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates; or (b) the date on which he ceases to be an employee; or (c) the date he is no longer eligible to participate under Section 2.1.

The Participant must apply for reimbursement before the earlier of (1) the 180th day following the date the Participant is terminated, and (2) the 90th day after the close of the Plan Year.

### **2.5 REINSTATEMENT OF FORMER PARTICIPANT**

A former Participant will become a Participant again if and when he meets the eligibility requirements of the Plan and upon completion of proper enrollment forms. A Participant whose coverage terminates as a result of a separation from the service of the Company shall not be permitted to make new benefit elections under this Plan upon reemployment during the Plan Year in which such previous coverage terminated. This limitation will not apply to the premium contribution benefit of the Plan.

### **3. ELECTION PROCESS**

#### **3.1 ELECTION PROCEDURE**

Each employee who works for the Company on a regular full-time basis will be eligible to participate in the plan. Approximately 30 days prior to the commencement of each Plan Year, the Administrator shall provide one or more written Election Forms and Compensation Reduction Agreements to each Participant and to each other employee who is eligible to become a Participant at the beginning of the Plan Year. The election forms shall be effective as of the first day of the Plan Year. Each Participant who desires one or more optional benefits for the Plan Year shall so specify on the appropriate election form or forms and shall agree to a reduction in his compensation. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 1.3, shall be the amount elected by the Participant, subject to the limitations of the Dependent Care Assistance Plan and the Medical/Dental Reimbursement Plan. Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the first pay day for which the Participant's Compensation Reduction Agreement will apply.

Health Plan contributions shall be automatically taken on a pre-tax basis unless the Employee elects out of the Health Plan contribution benefit. The amount of the reduction in the Participant's compensation for the Plan Year for a Company Sponsored benefit plan shall equal the Participant's share of the cost of the benefits and shall be adjusted automatically in the event of a change in any such cost.

#### **3.2 NEW EMPLOYEES**

As soon as practicable before an employee becomes a Participant, the Administrator shall provide the written Election Forms and Compensation Reduction Agreements to the employee. If the employee desires one or more optional benefits for the balance of the Plan Year, he shall so specify on the election forms and shall agree to a reduction in his compensation. The election forms must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Compensation Reduction Agreements will apply.

Company sponsored benefit Plan premium contributions shall be automatically taken on a pre-tax basis unless the Employee makes a written election to have premiums taken after tax.

#### **3.3 FAILURE TO ELECT**

A Participant failing to return a completed Election Form to the Administrator on or before the specified due date for the initial Plan Year of the Plan, or for the Plan Year in which he became a Participant, shall be deemed to have elected to receive his full compensation in cash. A Participant failing to return a completed election form to the Administrator relating to the optional benefits on or before the specified due date for any subsequent Plan Year shall be deemed to have elected cash compensation in lieu of such optional benefit, regardless of the election in effect during the preceding Plan Year.

Company sponsored benefit Plan premium contributions shall be automatically taken on a pre-tax basis unless the Employee makes a written election to have premiums taken after tax. This election will continue form year to year unless the Employee opts out in writing.

## **4. PREMIUMS FOR COTTINGHAM & BUTLER INSURANCE SERVICES, INC. SPONSORED PLANS**

### **4.1 CONTRIBUTIONS FOR PREMIUMS**

For purposes of any Company sponsored benefit Plan, offered under this Plan, an eligible Employee who is a participant in any Company sponsored benefit Plan will be deemed to be a Participant in this Plan and be deemed to have consented to a reduction in the Employee's compensation to permit contributions for any Company sponsored benefit Plan premium to be taken on a pre-tax basis. An eligible Employee may elect to have contributions for any Company sponsored benefit Plan taken after taxes by making an affirmative election not to participate when completing the enrollment paperwork for the Plan.

### **4.2 RIGHT OF COMPANY TO SUBSTITUTE PROVIDERS OR OPTIONS UNDER THE PLAN**

Cottingham & Butler Insurance Services, Inc. reserves the right to delete or substitute any provider or option, for the Company sponsored benefit plans at any time and without any further obligation to the Employees. Any affected Employee shall continue his election as modified. If any option is deleted, upon the next Plan anniversary date, any affected Employee may elect any option under the Plan and may be eligible for, or elect not to have such coverage under any option, to incur no salary reduction, and instead to receive his pay without such reduction.

## **5. MEDICAL/DENTAL REIMBURSEMENT ACCOUNTS**

### **5.1 ESTABLISHMENT OF ACCOUNTS**

The Company will establish and maintain on its books a Medical/Dental Reimbursement Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical/Dental Care Expenses incurred during the Plan Year.

### **5.2 CREDITING OF ACCOUNTS**

There shall be credited to a Participant's Medical/Dental Reimbursement Account for each Plan Year, as of each date compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such compensation in accordance with the Participant's election and compensation reduction agreement under the Flexible Spending Plan. All amounts credited to each such Medical/Dental Reimbursement Account shall be the property of the Company until paid out pursuant to the payment provisions of this Plan.

### **5.3 DEBITING OF ACCOUNTS**

A Participant's Medical/Dental Reimbursement Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Medical/Dental Care Services incurred during such Plan Year. Amounts debited to each such Medical/Dental Reimbursement Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

The maximum amount of reimbursement, minus any previous reimbursements, must be available throughout the Plan Year.

### **5.4 CLAIMS FOR REIMBURSEMENT**

A Participant who has elected to receive medical/dental care reimbursement for a Plan Year may apply to the Company for reimbursement of qualifying medical/dental expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Company in such form as the Company may prescribe, setting forth:

- A. The amount, date, and nature of the expense with respect to which a benefit is requested;
- B. The name of the person for whom the expense was incurred;
- C. A receipt or bill from the person or entity with whom the expense was incurred; and
- D. Such other information as the Company may from time to time require.

## **5.5 REIMBURSEMENT OR PAYMENT OF EXPENSES**

The Company shall reimburse the Participant from the Participant's Medical/Dental Reimbursement Account for Qualifying Medical Care Expenses incurred (medical/dental service is actually rendered) during the Plan Year for which the Participant submits in the form prescribed by the Company under Section 5.4. No reimbursement or payment of expenses incurred during a Plan Year shall at any time exceed the Participant's Medical/Dental Reimbursement Election for the Plan Year. The amount of any Qualifying Medical Care Expenses not reimbursed or paid as a result of the preceding sentence shall not be carried over to the following Plan Year.

## **5.6 FORFEITURE OF ACCOUNTS**

The amount credited to a Participant's Medical/Dental Reimbursement Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during such Plan Year or during the "grace period" as established by the Company, and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant's Medical/Dental Reimbursement Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during a subsequent Plan Year (except for the "grace period" as described below), and shall not be available to the Participant in any other form or manner, but shall remain the property of the Company for payment of reasonable administrative costs of the Plan, and the Participant shall forfeit all rights with respect to such balance.

## **5.7 GRACE PERIOD**

The Plan will allow expenses incurred during a "grace period" to be reimbursed from contributions for the current Plan Year. The "grace period" will be 2 ½ months, beginning on January 1 of the year following the current Plan Year and ending on March 15 of that year. For example, for the Plan Year January 1, 2010 through December 31, 2010, any eligible expenses incurred between January 1, 2011 and March 15, 2011 may be reimbursed from contributions remaining from the 2010 Plan Year. All claims for reimbursement must be filed on or before the 90<sup>th</sup> day following the close of the Plan Year.

## **5.8 MEDICAL/DENTAL REIMBURSEMENT ACCOUNT DISTRIBUTION FOR MEMBERS OF THE ARMED FORCES RESERVE**

A member of the Armed Forces reserve component who is ordered or called to active duty for a period of 180 days or longer may withdraw unused amounts in his health flexible spending account. The distribution will be subject to employment taxes and included in the employee's gross income on his W-2 for the year in which the withdrawal is made. Request for the withdrawal must be made beginning with the date of the order or call to active duty and ending on the last day of the Plan Year in which the employee was called to active duty. The employee will be eligible to withdraw the amount contributed to the Medical/Dental Reimbursement Account as of the date he terminates coverage under the Plan, minus any Medical/Dental reimbursements received as of that date.

## **6. DEPENDENT CARE ASSISTANCE ACCOUNTS**

### **6.1 ESTABLISHMENT OF ACCOUNTS**

The Company will establish and maintain on its books a Dependent Care Assistance Account for each Plan Year with respect to each Participant who has elected to receive dependent care assistance for the Plan Year.

### **6.2 CREDITING OF ACCOUNTS**

There shall be credited to a Participant's Dependent Care Assistance Account for each Plan Year, as of each date compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such compensation in accordance with the Participant's election and compensation reduction agreement under the Flexible Spending Plan. All amounts credited to each such Dependent Care Assistance Account shall be the property of the Company until paid out pursuant to the payment provisions of this Plan.

### **6.3 DEBITING OF ACCOUNTS**

A Participant's Dependent Care Assistance Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year. Amounts debited to each such Dependent Care Assistance Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

### **6.4 MAXIMUM DEPENDENT CARE ASSISTANCE**

The maximum amount which the Participant may receive in any Plan Year in the form of dependent care assistance under this Plan shall be the least of (a) the Participant's earned income for the Plan Year (after all reductions in compensation including the reduction related to dependent care assistance), or (b) the actual or deemed earned income of the Participant's spouse for the Plan Year. In addition, for any taxable year, the Participant may not receive more than the amount excludable with respect to such Participant under Internal Revenue Code Section 129(a) for the year in which dependent care assistance payments hereunder are made. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself, such spouse shall be deemed to have earned income of not less than \$200 per month if the Participant has one Dependent, and \$400 per month if the Participant has two or more Dependents. Charges are allowable only for dependent children under the age of thirteen (13), handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return.

To be eligible for Dependent Care Reimbursement, both spouses must be working or actively seeking work unless one is disabled or a full-time student. Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19) or a non-relative, as long as such person is reporting payments as income, is also eligible.

## 6.5 CLAIMS FOR REIMBURSEMENT

A Participant who has elected to receive dependent care reimbursement for a Plan Year may apply to the Company for reimbursement of qualifying dependent expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Company in such form as the Company may prescribe setting forth:

- A. The amount, date, and nature of the expense with respect to which a benefit is requested;
- B. The name of the person for whom the expense was incurred;
- C. A receipt or bill from the person or entity with whom the expense was incurred; and
- D. Such other information as the Company may from time to time require.

The Company shall reimburse the Participant from the Participant's Dependent Care Assistance Account for Dependent Care Expenses incurred during the Plan Year for which the Participant submits in the form prescribed by the Company. *No reimbursement or payment of expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Dependent Care Assistance Account at the time of the reimbursement or payment.* The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence shall be carried over and reimbursed or paid only if and when the balance in such Account permits such reimbursement or payment. No amount of non-reimbursed expenses shall be allowed to be carried forward to the subsequent Plan Year.

## 6.6 FORFEITURE OF ACCOUNTS

The amount credited to a Participant's Dependent Care Assistance Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year or during the "grace period" as established by the Company, and only if the Participant applies for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant's Dependent Care Assistance Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during a subsequent Plan Year (except for the "grace period" as described below), and shall not be available to the Participant in any other form or manner, but shall remain the property of the Company, and the Participant shall forfeit all rights with respect to such balance.

## 6.7 GRACE PERIOD

The Plan will allow expenses incurred during a "grace period" to be reimbursed from contributions for the current Plan Year. The "grace period" will be 2 ½ months, beginning on January 1 of the year following the current Plan Year and ending on March 15 of that year. For example, for the Plan Year January 1, 2007 through December 31, 2007, any eligible expenses incurred between January 1, 2008 and March 15, 2008 may be reimbursed from contributions remaining from the 2007 Plan Year. All claims for reimbursement must be filed on or before the 90<sup>th</sup> day following the close of the Plan Year.

## **7. RIGHTS UNDER ERISA**

### **7.1 Your Rights**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:

#### **7.2 Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

#### **7.3 Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

#### **7.4 Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**7.5 Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **8. PLAN ADMINISTRATION**

### **8.1 CAFETERIA PLAN STATUS**

This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125.

### **8.2 NAMED FIDUCIARY AND PLAN ADMINSTRATOR**

The Named Fiduciary and Plan Administrator is Cottingham & Butler Insurance Services, Inc. who shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Company shall have the authority to amend the Plan, to determine its policies, to appoint and remove persons or entities to be responsible for administering any aspects of the Plan, fix their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

### **8.3 PLAN IS NOT A CONTRACT**

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Participant of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

### **8.4 LIMITATION OF RIGHTS**

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving any Participant or other person any legal or equitable right against the Company, except as provided herein.

### **8.5 CONFORMITY WITH GOVERNING LAW**

To the extent not preempted by ERISA, this Plan shall be construed, administered, and enforced according to the laws of the State of Iowa. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

### **8.6 INDEMNIFICATION OF ADMINISTRATOR**

The Company agrees to indemnify and to defend to the fullest extent permitted by law any employee serving as the Administrator or as a member of a committee designated as Administrator (including any employee or former employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

## **8.7 NONDISCRIMINATORY EXERCISE OF AUTHORITY**

Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

## **8.8 ADMINISTRATIVE POWERS AND DUTIES OF THE PLAN ADMINISTRATOR AND CLAIMS PROCESSOR**

The Plan Administrator and the claims processor shall have the following administrative responsibilities and authority with respect to the Plan:

1. Make such uniform and non-discriminatory rules and regulations for the administration and interpretation of the Plan as are consistent with the terms hereof or of applicable laws.
2. Establish and maintain records appropriate to permit the Plan to be administered according to its terms and requirements of applicable laws.
3. Prepare and file or otherwise disseminate all reports, filings and documents required by applicable laws or regulations.
4. With the advance approval of the Plan Administrator, the claims processor may employ one or more persons, including an enrolled actuary, an independent qualified public accountant, and/or counsel, to perform such duties as may from time to time be required and to render advice upon request with regard to any matters arising under the Plan.
5. Interpret the Plan and decide any matters arising hereunder in the administration and operation of the plan, and any interpretations or decisions so made will be conclusive and binding on all persons having an interest in the Plan; provided, however, that all such interpretations and decisions shall be applied in a uniform manner to all Employees similarly situated.
6. Establish in writing a claims procedure in accordance with the appropriate plan documents (as modified by this Plan) which provide the benefits, and in accordance with regulations of the Secretary of Labor.
7. Take all other steps deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable laws.

## **8.9 EXAMINATION OF RECORDS**

The Administrator will make available to each Participant such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

## **8.10 RELIANCE ON TABLES, ETC.**

In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, the administrators of the Dependent Care Assistance and Medical/Dental Reimbursement Plans, or by accountants, counsel, or other experts employed or engaged by the Administrator.

### **8.11 CLAIMS DENIAL AND REVIEW PROCEDURE**

All claims must be filed with the Plan within 90 days following the end of the Plan Year. If any such claim is wholly or partially denied, the Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary for such person to perfect such claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if the person wishes to submit a request for review. Such notification will be given within 30 days after the claim is received by the Administrator (or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and such person may request a review of his claim.

Within 180 days after the date on which a person receives a written notice of a denied claim (or, if applicable, within 180 days after the date on which such denial is considered to have occurred) such person (or his duly authorized representative) may (i) file a written request with the Administrator for a review of his denied claims and of pertinent documents, and (ii) submit written issues and comments to the Administrator. The Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain specific reasons for the decisions as well as specific references to pertinent Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Administrator to hold a hearing, and if written notice of such extension and circumstance is given to such person within the initial 60 day period).

### **8.12 REPORT TO PARTICIPANTS ON OR BEFORE JANUARY 31 OF EACH YEAR**

On or before January 31 of each year, the Administrator shall furnish to each Participant who has received dependent care assistance during the prior calendar year a written statement showing the amount of such reimbursements received during such year with respect to the Participant.

### **8.13 PERMITTED AND REQUIRED USES OF PROTECTED HEALTH INFORMATION**

Protected Health Information (PHI) is individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium. PHI will only be released to the "Privacy Officials" appointed by the Company. A list of Privacy Officials may be obtained from the Company.

Your health Plan will only provide Protected Health Information to the Plan Sponsor upon receipt of certification that the Plan Sponsor will agree to:

1. Not use or disclose the PHI other than as permitted or required by the Plan Document or as required by law;
2. Ensure that agents and subcontractors to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions as the Plan Sponsor;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the group health Plan any PHI use or disclosure, of which it becomes aware, that violates the permitted uses or disclosures under HIPAA;
5. Make PHI available in accordance with HIPAA Access Requirements;
6. Make PHI available for amendment and incorporate those amendments as required by the privacy regulations;
7. Make information available to provide an accounting of disclosures as provided in the privacy regulations;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of the Department of Health and Human Services;
9. If feasible, at termination of the relationship, return or destroy all PHI received from the group health plan, but if return or destruction is not feasible, limit further uses or disclosures to those purposes that make return or destruction of the information infeasible; and
10. Ensure adequate separation between employees who are authorized to use PHI and those who are not.

Any information supplied to the Plan Sponsor in order to process claims and claim payment will be kept confidential by all individuals within the Company who use this information in the normal course of business. These individuals will restrict access to and use of PHI by individuals other than for plan administration functions that the Plan Sponsor performs for the group health plan. Misuse or disclosure of PHI by any individual in the Company may result in disciplinary sanctions, such as dismissal. The Company shall provide a mechanism for resolving issues of noncompliance. PHI will not be disclosed to a Plan Sponsor for employment-related activities or decisions or in connection with any other benefit plan of the Plan Sponsor.

#### **8.14 HIPAA SECURITY PROVISION**

Where electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. sect. 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and

4. Plan Sponsor shall report to the Plan any “Security Incidents” of which it becomes aware as described below (“Security Incidents” has the meaning set forth in 45 C.F.R. sect. 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system):
  - a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any “Security Incident” that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s electronic Protected Health Information; and
  - b) Plan Sponsor shall report to the Plan any other “Security Incident” on an aggregate basis every quarter, or more frequently upon the Plan’s request.

## **9. AMENDMENTS TO OR TERMINATION OF THE PLAN**

### **9.1 PLAN AMENDMENTS**

This document contains all the terms of the Plan and may be amended from time to time by the Company. Any changes so made shall be binding on each Covered Participant and on any other Covered Persons referred to in this Plan Document.

### **9.2 CHANGES BY ADMINISTRATOR**

If the Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated employees or Key Employees with or without the consent of such employee.

### **9.3 TERMINATION OF PLAN**

The Company reserves the right at any time to terminate the Plan by a written instrument to that effect. Claims arising prior to the effective date of termination will be paid if proof of such claims is submitted to the Plan Administrator in accordance with the Dependent Care Assistance Plan and the Medical/Dental Reimbursement Plan. Such claims must be submitted on or before the 90th day following the effective date of the Plan termination.

## **10. MISCELLANEOUS**

### **10.1 RIGHTS OF EMPLOYEES**

Nothing herein contained shall be deemed to give any Employee the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge such Employee at any time, nor shall it be deemed to give the Company the right to require the Employee to remain in its employ, nor shall it interfere with the Employee's right to terminate his employment at any time.

### **10.2 NOTICE OF ADDRESS**

Each person entitled to benefits under the Plan must file with the Plan Administrator, in writing, his post office address and each change of post office address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the plan, and there shall be no obligation on the part of the Plan Administrator and the claims processor to search for or to ascertain the location of such person.

### **10.3 DATA**

Each person entitled to benefits under the Plan must furnish to the Plan Administrator and the claims processor such documents, evidence, or other information as considered necessary or desirable for the purposes of administering the Plan or to protect the Plan. The Plan Administrator and the claims processor shall be entitled to rely on representations made by Employees, with respect to age, marital status and other personal facts, unless it knows said representations are false.

### **10.4 HEADINGS**

The headings of the Plan are inserted for convenience and reference and shall have no effect upon the meaning of the provisions hereof.

### **10.5 CONSTRUCTION**

The Plan shall be construed, regulated and administered under the laws of Iowa, except that if any such laws are superseded by any applicable Federal law or statute, such Federal law or statute shall apply.

## **11. DEFINITIONS**

### **11.1 CODE**

The term "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

### **11.2 COMPANY**

The term "Company" means Cottingham & Butler Insurance Services, Inc.

### **11.3 DEPENDENT**

The term "Dependent" means any person who falls within the definition of dependent provided in Section 152 of the Code.

### **11.4 DEPENDENT CARE ASSISTANCE PLAN**

The term "Dependent Care Assistance Plan" means the Cottingham & Butler Insurance Services, Inc. Dependent Care Assistance Plan as amended from time to time.

### **11.5 EMPLOYEE**

The term "employee" means any individual employed by Cottingham & Butler Insurance Services, Inc.

### **11.6 EMPLOYMENT**

The term "employment" means a basis whereby a Participant is employed by the Company. Such work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Participant to travel, and for which he receives regular earnings from the Company.

### **11.7 ERISA**

The term "ERISA" means the Employee Retirement Income Security Act of 1974, and as amended from time to time.

### **11.8 KEY EMPLOYEE**

The term "Key Employee" means any person who is a Key Employee as defined in Section 416(i)(1) of the Code.

### **11.9 MEDICAL/DENTAL REIMBURSEMENT PLAN**

The term "Medical/Dental Reimbursement Plan" means the Cottingham & Butler Insurance Services, Inc. Medical/Dental Reimbursement Plan as amended from time to time.

### **11.10 PARTICIPANT**

The term "Participant" means any individual who participates in the Plan in accordance with the provisions of Article 3.

### **11.11 PLAN**

The term "Plan" means the Cottingham & Butler Insurance Services, Inc. Flexible Compensation Plan, as set forth herein, together with any and all amendments and supplements hereto.

### **11.12 PLAN ADMINISTRATOR**

The term "Plan Administrator" means the Company or such other person or committee as may be appointed from time to time by the Company to supervise the administration of the Plan.

### **11.13 PLAN SPONSOR**

The term "Plan Sponsor" means Cottingham & Butler Insurance Services, Inc.

### **11.14 PLAN YEAR**

The term "Plan Year" means the period beginning on January 1<sup>st</sup> through December 31<sup>st</sup>. In the event a Participant commences participation during a Plan Year, the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year. For the Medical Expenses Reimbursement Account, the "Plan Year" for incurring expenses will extend for an additional two (2) months and 15 days. Contributions will be taken over a period of twelve (12) months, but eligible expenses may be incurred during a 14 ½ month time period.

### **11.15 QUALIFYING MEDICAL CARE EXPENSE**

The term "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 paid for hospital bills, doctor and dental bills, and drugs) with the exception of premiums for coverage, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under the Plan).

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

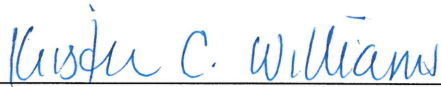
IN WITNESS WHEREOF, the Company has caused this Plan to be executed in its name and behalf this 5 day of September, 2010, by its officer thereto duly authorized.

COTTINGHAM & BUTLER INSURANCE SERVICES, INC.

By:   
Authorized Signature

VP, HR  
Title

Witness:

By: 

# ADDITIONAL BENEFITS DEBIT CARD REQUEST FORM



PARTICIPANT INFORMATION		
GROUP NAME:	BCC GROUP NUMBER:	
EMPLOYEE NAME:	EMPLOYEE SSN:	
EMPLOYEE STREET ADDRESS:		
CITY:	STATE:	ZIP:
PARTICIPANT AUTHORIZATION: <i>By signing below, I authorize an additional Benefits Debit Card linked to my BCC Administered Reimbursement Account to be generated and mailed to my dependent spouse/child listed below.</i>		
PARTICIPANT SIGNATURE:		DATE:
ADDITIONAL BENEFITS DEBIT CARD HOLDER INFORMATION		
<i>The dependent spouse or child must be 18 years of age or older to receive a benefits debit card.</i>		
NAME:		
SSN:		
DATE OF BIRTH:		
IS SHIPPING ADDRESS DIFFERENT FROM EMPLOYEE ADDRESS LISTED ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, STREET ADDRESS:		
CITY:	STATE:	ZIP:
RELATIONSHIP TO EMPLOYEE: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT (OVER 18 YEARS OF AGE)		

## SUBMIT THIS FORM TO BENEFIT COORDINATORS CORPORATION (BCC):

- Fax: 412-276-7185
- E-Mail: [bcc-claims@benXcel.com](mailto:bcc-claims@benXcel.com)
- Mail: Benefit Coordinators Corporation, Attn: Claims  
Two Robinson Plaza, Suite 200  
Pittsburgh, PA 15205
- Download to BCC's secure FTP website: <http://secure.benxcel.com>

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# DAYCARE CONTRACT

## Flexible Spending Dependent Care Annual Contract (This contract needs to be filled out yearly)

### Terms of Contract

My Contract Year will begin on \_\_\_\_\_, and will end on \_\_\_\_\_.

EMPLOYEE NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employee signature: \_\_\_\_\_

This form is being submitted to establish that a contract for services exists between me and the individual/entity who has signed below in which I have agreed to purchase dependent care services for the period indicated.

PROVIDER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I/We agree to provide day care services for the above mentioned employee. This service will be provided on the following basis:

Time Period	Frequency	Rate of Pay
_____ A.M. to _____ P.M.	Daily	\$ _____ Hourly
	Weekly	\$ _____ Daily
	Monthly	\$ _____ Weekly

Based on the above schedule, it is anticipated that the above mentioned employee will incur fees which will total, during the period stated above, a minimum of:

\$ \_\_\_\_\_

This statement is signed this \_\_\_\_\_ day of 20

PROVIDER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

TITLE \_\_\_\_\_

PROVIDER'S SS# OR EIN# \_\_\_\_\_

Note: The IRS requires a W-10 form completed for services provided.

*If the terms of this contract were to change at any time, you will need to contact us and a new contract will need to be filled out and sent to us.*



# FSA CHANGE IN FAMILY STATUS GUIDELINES

EVENT	HEALTH FSA	DEPENDENT CARE FSA
<b>Change in Employee's Legal Marital Status</b>		
Gain Spouse	<ul style="list-style-type: none"> <li>• Enroll or increase election for newly eligible spouse/dependent</li> <li>• Decrease election if employee or dependent become eligible under new spouse's health plan</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll or increase election for newly eligible dependent</li> <li>• Decrease or cease coverage if new spouse is not employed or if new spouse makes a dependent care election under new spouse's plan</li> </ul>
Lose Spouse	<ul style="list-style-type: none"> <li>• Decrease election to reflect loss of spouse's eligibility</li> <li>• Enroll or increase election where coverage is lost under lost spouse's health plan</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll or increase election to accommodate newly eligible dependent</li> <li>• Cease coverage if eligibility is lost</li> </ul>
<b>Change in the Number of Employee's Dependents</b>		
Gain Dependent(s)	<ul style="list-style-type: none"> <li>• Enroll or increase election for newly eligible dependent</li> <li>• Cease or decrease election if employee or dependent become eligible under spouse's plan</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll or increase election to accommodate newly eligible dependent</li> </ul>
Lose Dependent(s)	<ul style="list-style-type: none"> <li>• Cease or decrease election for dependent who lose eligibility</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease election for dependent who loses eligibility</li> </ul>
<b>Commencement of Employment by Employee, Spouse, or Dependent that Triggers Eligibility</b>		
Start of Employment by Employee OR Other Change in Employment Status	<ul style="list-style-type: none"> <li>• Provided that eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependent</li> </ul>	<ul style="list-style-type: none"> <li>• Provided that eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependent</li> </ul>
Start of Employment by Spouse/Dependent OR Other Change in Employment Status Triggering Eligibility Under Spouse's/ Dependent's Plan	<ul style="list-style-type: none"> <li>• Decrease or cease election if employee gains eligibility for Health coverage under spouse's/dependent's plan</li> </ul>	<ul style="list-style-type: none"> <li>• Employee may make or increase election to reflect new eligibility</li> <li>• Cease election for dependent's coverage if dependent is added to spouse's plan</li> </ul>
<b>Termination of Employment by Employee, Spouse, or Dependent that Causes Loss of Eligibility</b>		
Term of Employee's Employment OR Other Change in Employment Status Resulting in a Loss of Eligibility	<ul style="list-style-type: none"> <li>• Cease election to reflect loss of eligibility</li> </ul>	<ul style="list-style-type: none"> <li>• Cease or decrease election to reflect loss of eligibility</li> </ul>
Term & Rehire within 30 Days	<ul style="list-style-type: none"> <li>• Prior elections at termination are reinstated unless another event has occurred that allows a change</li> </ul>	<ul style="list-style-type: none"> <li>• Prior elections at termination are reinstated unless another event has occurred that allows a change</li> </ul>
Term & Rehire after 30 Days	<ul style="list-style-type: none"> <li>• Employee may make new election</li> </ul>	<ul style="list-style-type: none"> <li>• Employee may make new election</li> </ul>
Term of Spouse's/ Dependent's Employment	<ul style="list-style-type: none"> <li>• Enroll or increase election to reflect loss of eligibility for health coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll or increase election if spouse/dependent loses eligibility for this coverage</li> <li>• Decrease or cease election to reflect loss of eligibility for this coverage</li> </ul>



# FSA CHANGE IN FAMILY STATUS GUIDELINES

EVENT	HEALTH FSA	DEPENDENT CARE FSA
<b>Termination of Employment by Employee, Spouse, or Dependent that Causes Loss of Eligibility</b>		
Term of Employee's Employment OR Other Change in Employment Status Resulting in a Loss of Eligibility	<ul style="list-style-type: none"> <li>• Cease election to reflect loss of eligibility</li> </ul>	<ul style="list-style-type: none"> <li>• Cease or decrease election to reflect loss of eligibility</li> </ul>
Term & Rehire within 30 Days	<ul style="list-style-type: none"> <li>• Prior elections at termination are reinstated unless another event has occurred that allows a change</li> </ul>	<ul style="list-style-type: none"> <li>• Prior elections at termination are reinstated unless another event has occurred that allows a change</li> </ul>
Term & Rehire after 30 Days	<ul style="list-style-type: none"> <li>• Employee may make new election</li> </ul>	<ul style="list-style-type: none"> <li>• Employee may make new election</li> </ul>
Term of Spouse's/ Dependent's Employment	<ul style="list-style-type: none"> <li>• Enroll or increase election to reflect loss of eligibility for health coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll or increase election if spouse/dependent loses eligibility for this coverage</li> <li>• Decrease or cease election to reflect loss of eligibility for this coverage</li> </ul>
<b>Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements</b>		
Event in which Dependent Satisfies Eligibility Requirements under Employer's Plan	<ul style="list-style-type: none"> <li>• Increase election or enroll only if dependent gains eligibility under this plan</li> </ul>	<ul style="list-style-type: none"> <li>• Increase election or enroll to take into account expenses of affected dependent</li> </ul>
Event in which Dependent Ceases to Satisfy Eligibility Requirements under Employer's Plan	<ul style="list-style-type: none"> <li>• Decrease or cease election to take into account ineligibility of expenses of affected dependent but only if eligibility is lost. If dependent remains a tax dependent and this plan provides that the dependent's expenses remain eligible for reimbursement, then the employee could increase this plan's election</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease or cease election to take into account expenses of affected dependent</li> </ul>
<b>Change in Place of Residence of Employee, Spouse, or Dependent</b>		
Move Triggers Eligibility	<ul style="list-style-type: none"> <li>• No change allowed</li> </ul>	<ul style="list-style-type: none"> <li>• N/A (this plan's eligibility is not generally affected by place of residence)</li> </ul>
Move Causes Loss of Eligibility	<ul style="list-style-type: none"> <li>• No change allowed</li> </ul>	<ul style="list-style-type: none"> <li>• N/A (this plan's eligibility is not generally affected by place of residence)</li> </ul>





# My SmartCare Debit Card Mobile Wallet Capabilities

BCC's My SmartCare online portal and mobile app now allow you to add your BCC SmartCare Debit Card to your personal Mobile Wallet on your mobile device

## Steps to Complete your Mobile Wallet Setup:

1. Grab your mobile device and open up your Mobile Wallet
  - Currently, the following apps are supported:
    - Apple Pay
    - Google Pay
    - Samsung Pay



2. Click 'Add' or '+' to add a new debit or credit card into your Mobile Wallet and either scan your BCC SmartCare debit card or enter the card details manually.

3. After adding your debit card to your mobile wallet, an additional validation step is required. To accomplish this, you must have either an email or phone number on file in SmartCare. If you do not, you will receive an error message in your mobile wallet and will be unable to add the card.

- The available methods of validation are listed below:
  - Email Method
    - A one-time passcode is emailed to the you, which you must enter into the mobile wallet interface
      - This email will be sent from [donotreply@mobilewalletverification.com](mailto:donotreply@mobilewalletverification.com).
      - The text of the email reads "Your Mobile Pay verification code is XXXXXX."
  - SMS Text Message
    - A one-time passcode is sent via SMS text message to you, which you must enter into the mobile wallet interface
      - The text message reads "Your Mobile Pay verification code is XXXXXX."
  - Calling My SmartCare Customer Service
    - An Alegeus-managed customer service phone number will display as an option for you to call to complete validation

4. Once validated, you should now be able to access and utilize your BCC SmartCare Debit Card through your Mobile Wallet

