The Federal Flexible Benefits Plan

“FedFlex”

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THE FEDERAL FLEXIBLE BENEFITS PLAN

Article 1. INTRODUCTION.

1.1 Purpose of Plan. The purpose of this Plan is to provide Employees a choice between cash and pre-tax coverage under a Medical Plan, Vision Plan, Dental Plan, Health Care Flexible Spending Arrangement (HCFSA) and/or Dependent Care Flexible Spending Arrangement (DCFSA).

1.2 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 applicable regulations, and is to be interpreted in a manner consistent with the requirements of Section 125.

1.3 Flexible Spending Arrangement Plan Status. The HCFSAs are offered pursuant to a self-insured medical expense reimbursement plan under Code Section 105. The DCFSAs are offered under Code Section 129. FSAs are intended to allow Employees to pay medical and dependent care expenses using pre-tax dollars and are intended not to discriminate as to eligibility or benefits in favor of the prohibited group under Code Sections 105, 125, and 129.

Article 2. DEFINITIONS.

Whenever used, these terms have the following meanings unless a different meaning is clearly required by the context:

2.1 "Adopting Employer" means the Executive Branch of the Federal Government. Adopting Employer also means an Employer that signs an adoption agreement, accepted by OPM, to participate in this Plan. An Employer remains an Adopting Employer until the Plan terminates, the Adopting Employer withdraws from the Plan, or OPM terminates the Adopting Employer's participation in the Plan.

2.2 "Benefit Period" means the period of time during which a Covered Employee may incur Eligible Health Care Expenses or Eligible Dependent Care Expenses and may be paid or reimbursed for such expenses. For the DCFSA, this period is the Plan Year and the Grace Period. For an HCFSA, this period is the Plan Year.

2.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.4 "Covered Employee" means an individual who is an Employee under Section 2.12, is employed by an Adopting Employer, and satisfies coverage requirements under Article 3.

2.5 Reserved

2.6 "Dental Supplemental Benefit Plan" or "Dental Plan" means a dental benefits plan participating in the Federal Employees Dental and Vision Insurance Program "FEDVIP" established under 5 U.S.C. Chapter 89A.

2.7 **"Dependent"** for purposes of HCFSA and DCFSA, and no other purpose, means any individual who is a tax dependent of the Covered Employee as defined in Code Section 152(a) and with respect to whom the Covered Employee is entitled to an exemption under Code Section 151(c). For the purpose of a HCFSA, an individual's status as a dependent is determined without regard to Code Section 152(b)(1), (b)(2), and (d)(1)(B). A child described in Code Section 152(e) shall be treated as a dependent of both parents (except that for purposes of a DCFSA, if the parents are divorced or separated, the individual is the dependent of the custodial parent).

2.8 **"Dependent Care Flexible Spending Arrangement"** or **"DCFSA" or "Day Care FSA"** means an account established by the Employer for designated allotments made by the Employee for reimbursement of Eligible Dependent Care Expenses.

2.9 **"Effective Date"** for an Employer means the date that an Employer becomes an Adopting Employer.

2.10 **"Eligible Dependent Care Expenses"** is defined in Section 4.4.c.

2.11 **"Eligible Health Care Expenses"** is defined in Section 4.3.1.c. A Covered Employee who holds an HSA or whose spouse holds an HSA may only incur eligible health care expenses under the LEX HCFSA. These expenses are described in Section 4.3.2.1 as LEX HCFSA Eligible Health Care Expenses.

2.12 **"Employee"** means

a. For purposes of the Medical Plan and the Health Care Flexible Spending Arrangement, and no other purpose

1. an employee as defined in 5 U.S.C. Section 8901(1) except that Employee does not include: employees of the Judicial Branch; employees of the District of Columbia government; or employees not eligible to participate in the FEHB Program in accordance with applicable statutes and regulations; or

2. a Reemployed Annuitant.

b. For purposes of the Dependent Care Flexible Spending Arrangement, and no other purpose

1. an employee as defined in 5 U.S.C. Section 8901(1); except that Employee does not include: employees of the Judicial Branch; employees of the District of Columbia government; intermittent employees with no fixed work schedule whose tour of duty is expected to be 180 days or less; or

2. a Reemployed Annuitant.

c. For purposes of the Dental Plan and the Vision Plan and no other purpose

1. an employee of the United States Postal Service, and employee of the District of Columbia Courts or an employee as defined in 5 U.S.C. Section 8901(1) except that Employee does not include employees not eligible to participate in the FEHB Program in accordance with applicable statutes and regulations; or

2. a Reemployed Annuitant.

2.13 **"Employer"** means an employer of an Employee. In the case of an Employee whose payroll office is not an Executive Branch payroll office, the Employer is the entity that issues pay on behalf of the Employee.

a.

1.

2.14 **"FEHB Program"** means Federal Employees Health Benefits Program described in 5 U.S.C. Section 8901, et seq.

2.15 **"Flexible Spending Arrangements"** or **"FSA"** means Health Care Flexible Spending Arrangement and Dependent Care Flexible Spending Arrangement.

2.16 **"Form"** means a paper form, electronic enrollment or other written notice approved by OPM.

2.17 **"FSA Initial Effective Date"** means July 1, 2003.

2.18 **"FSA Initial Plan Year"** for an Employer means the period beginning on the FSA Initial Effective Date and ending on December 31 of that same year.

2.19 **"Grace Period"** means the two month and 15 day period immediately following the end of a Plan Year during which a Covered Employee may incur Eligible Dependent Care Expenses and may be paid or reimbursed for such expenses.

2.20 **"Health Care Flexible Spending Arrangement"** or **"HCFSA"** means an account established by the Employer for designated allotments made by the Employee for reimbursement of Eligible Health Care Expenses. A Covered Employee who holds an HSA or whose spouse holds an HSA may only enroll in a HCFSA for limited expenses, known as a LEX HCFSA.

2.21 **"Health Savings Account"** or **"HSA"** means an account as defined in Code Section 223.

2.22 **"High Deductible Health Plan" or "HDHP"** means a health benefits plan as defined in Code Section 223.

2.23 **"Initial Effective Date"** for the Executive Branch of the Federal Government means October 1, 2000.

2.24 **"Initial Effective Date for Dental Plan and Vision Plan"** for the Executive Branch of the Federal Government means December 31, 2006.

2.25 **"Initial Plan Year"** for an Employer means the period beginning on the Effective

Date and ending on December 31 of that same year.

2.26 **"Initial Plan Year for Dental Plan and Vision Plan"** for an Employer means the period beginning on the Initial Effective Date for Dental Plan and Vision Plan and ending on December 31 of the subsequent Plan Year.

2.27 **"Limited Purpose Health Care Flexible Spending Arrangement"** means an account as defined in Section 4.3.2.

2.28 **"Limited Expense HCFSA"** or **"LEX HCFSA"** means an account as defined in Section 4.3.2.1

2.29 **"Limited Enrollment HCFSA"** or **"LEN HCFSA" [RESERVED].**

2.30 **"Limited Expense Limited Enrollment HCFSA"** or **"LEXLEN HCFSA" [RESERVED].**

2.31 **"Medical Plan"** means an OPM-contracted FEHB health benefits plan or a health benefits plan offered by an appropriate SHOP as determined by the Director pursuant to section 1312(d)(3)(D) of the Affordable Care Act [42 USC 18032(d)(3)(D)].

2.32 **"OPM"** means the United States Office of Personnel Management.

2.33 **"Plan"** means The Federal Flexible Benefits Plan as set forth, together with any and all amendments, supplements and regulations published under Title 5 of the Code of Federal Regulations. If there is a conflict between The Federal Flexible Benefits Plan and the regulations, the regulations will govern. The Plan may also be known as "FedFlex."

2.34 **"Plan Agent"** means a third party administrator under contract to OPM to provide designated administrative services with regard to the Plan.

2.35 **"Plan Administrator"** means OPM.

2.36 **"Plan Year"** means the 12-month period ending on each December 31 after the Initial Plan Year.

2.37 **"Qualifying Dependent"** for purposes of DCFSA, and no other purpose, means:

a. a Dependent of the Covered Employee who is under the age of thirteen (13); or

b. a Dependent or spouse of the Covered Employee who is mentally or physically incapable of caring for himself or herself.

In the case of divorced parents, the child is treated as a qualifying dependent of the custodial parent as provided under Code Section 21(e)(5).

2.38 **"Qualified Reservist"** means a Covered Employee (but not the spouse or Dependent of a Covered Employee) who is a member of: the Army National Guard;

the Air National Guard; the Army Reserve; the Navy Reserve; the Marine Corps Reserve; the Air Force Reserve; the Coast Guard Reserve; or the Reserve Corps of the Public Health Service.

2.39 **"Qualified Reservist Distribution"** or **"QRD"** means the taxable distribution of the balance of a Qualified Reservist's HCFSA as set forth in Section 4.22.

2.40 **"Reemployed Annuitant"** means an individual who is retired from the Federal Government, is reemployed as an employee as defined in 5 U.S.C. Section 8901(1), and who continues to receive an annuity.

2.41 **"Summary of Benefits"** means a written document available during each FEHB open season that describes the flexible spending arrangement benefits under the Plan.

2.42 **"Temporary Continuation of Coverage"** or **"TCC"** means coverage that may be available to a Covered Employee who leaves Federal service, or to a dependent who loses coverage because he or she no longer qualifies as an eligible family member, or to a child who turns age 26 and loses coverage under the Medical Plan.

2.43 **"U.S.C."** means the United States Code, as amended from time to time.

2.44 **"Vision Supplemental Benefit Plan" or "Vision Plan"** means a vision benefits plan participating in the Federal Employees Dental and Vision Insurance Program (FEDVIP) established under 5 U.S.C. Chapter 89B.

Article 3. COVERAGE

3.1 **Commencement of Coverage under the Plan.**

a. An employee will become a Covered Employee on the latest of:

1. The Effective Date for his or her Adopting Employer; or

2. The first day he or she becomes an Employee.

b. If an Employee is eligible to participate in a cafeteria benefit plan offered by another Executive Branch Employer, then that Employee is not covered under this Plan with respect to the same or similar type of benefit offered by the other Executive Branch Employer (with the exception of dental and/or vision benefits). In addition, no Employee may be covered under more than one premium conversion plan for premiums paid to: (a) the Medical Plan; or (b) the Dental Plan; or (c) the Vision Plan, respectively.

3.2 **Termination of Coverage under the Plan.** A Covered Employee will cease to be a Covered Employee as of the earliest date on which any of the following occurs:

a. the Plan terminates;

b. he or she ceases to be an Employee;

c. the date the Covered Employee's election or deemed election to receive benefits under the Plan terminates; or

d. the Covered Employee's Employer ceases to be an Adopting Employer.

3.3 **Reinstatement of Former Covered Employee.** A former Covered Employee will become a Covered Employee again if and when he or she meets the coverage requirements of Section 3.1. A reinstated Covered Employee's election will be subject to the provisions of Section 4.16.

Article 4. OPTIONAL BENEFITS COVERAGES.

4.1 **Coverage Options.** Each Covered Employee may choose under this Plan to receive his or her pay for any Plan Year in cash or to have a portion of it applied on a pre-tax basis as Employer provided coverage toward (a) the Medical Plan; (b) the Dental Plan; (c) the Vision Plan; (d) an HCFSA; and/or (e) a DCFSA.

4.1.1 **Account Option.** Each Covered Employee may choose under this Plan to receive his or her pay in cash or to have a portion of it applied on a pre-tax basis as an Employer provided contribution toward an HSA pursuant to Section 4.5.

4.2 **Options for Medical Plan, Dental Plan and Vision Plan.**

a. Coverage and benefits to be provided by the Medical Plan. Medical Plan coverage and benefits will be provided not by this Plan but by the Medical Plan. The types and amounts of benefits available under the Medical Plan, the requirements for participating in the Medical Plan and the other terms and conditions of coverage and benefits under the Medical Plan are as set forth in 5 U.S.C. Section 8901, et seq. and 42 U.S.C. Section 18032, applicable regulations, and applicable official statements of benefits, all of which are incorporated by reference into this Plan.

b. Coverage and benefits to be provided by the Dental Plan. Dental Plan coverage and benefits will be provided not by this Plan but by the Dental Plan. The types and amounts of benefits available under the Dental Plan, the requirements for participating in the Dental Plan and the other terms and conditions of coverage and benefits under the Dental Plan are as set forth in 5 U.S.C. Chapter 89A, and applicable regulations as well as the Dental Plan contracts and benefit brochures, all of which are incorporated by reference into this Plan.

c. Coverage and benefits to be provided by the Vision Plan. Vision Plan coverage and benefits will be provided not by this Plan but by the Vision Plan. The types and amounts of benefits available under the Vision Plan, the requirements for participating in the Vision Plan and the other terms and conditions of coverage and benefits under the Vision Plan are as set forth in 5 U.S.C. Chapter 89B, and applicable regulations as well as the Vision Plan contracts and benefit brochures, all of which are incorporated by reference into this Plan.

d. Cash. A Covered Employee may elect to receive cash in lieu of the optional pre-tax premiums for Medical Plan, Dental Plan, and/or Vision Plan coverage described in

Section 4.2.a, 4.2.b, and 4.2.c, respectively, in accordance with the election procedures described in Sections 4.7, 4.8, and 4.9. For purposes of the Medical Plan only, a Covered Employee may use cash to participate in a Medical Plan on an after-tax basis. The Employer will continue to pay its share of the cost of premiums under the Medical Plan.

e. Pre-tax Medical Plan coverage. If a Covered Employee does not elect the cash option under this section, the Covered Employee's pay will be reduced through an allotment as described in Section 4.6, and an amount equal to the reduction will be contributed by the Employer to a Medical Plan designated by the Covered Employee to cover the Covered Employee's share of the cost of the premium.

f. Pre-tax Dental Plan coverage. If a Covered Employee elects to enroll in the Dental Plan, the Covered Employee's pay will be reduced through an allotment as described in Section 4.6, and an amount equal to the reduction will be contributed by the Employer to a Dental Plan designated by the Covered Employee to cover the Covered Employee's Dental Plan premium.

g. Pre-tax Vision Plan coverage. If a Covered Employee elects to enroll in the Vision Plan, the Covered Employee's pay will be reduced through an allotment as described in Section 4.6, and an amount equal to the reduction will be contributed by the Employer to a Vision Plan designated by the Covered Employee to cover the Covered Employee's Vision Plan premium.

4.3. Health Care Flexible Spending Arrangement Options

a. FedFlex offers Covered Employees a traditional general purpose Health Care Flexible Spending Arrangement (HCFSA) as described in Section 4.3.1, or a Limited Purpose Health Care Flexible Spending Arrangement (LEX HCFSA), as described in Sections 4.3.2.

4.3.1 Health Care Flexible Spending Arrangement.

a. Cash. A Covered Employee will receive cash in lieu of the optional pre-tax coverage described below, in accordance with the procedures described in Sections 4.10 and 4.11.

b. Health Care Flexible Spending Arrangement allotment. A Covered Employee may make an allotment as described in Section 4.6 and an amount equal to the allotment will be contributed by the Employer to an HCFSA to pay for Eligible Health Care Expenses incurred during the HCFSA Benefit Period. A Covered Employee who makes an allotment to an HCFSA and the spouse of the Covered Employee are not eligible to contribute to an HSA.

c. Eligible Health Care Expenses. Eligible medical, dental, and vision expenses are expenses incurred during the Benefit Period and while the Employee is a Covered Employee, by the Covered Employee, or the Covered Employee’s spouse, Dependent or child defined at 26 U.S.C. § 152(f)(1) who has not attained the age of 27 as of the end of the Covered Employee’s taxable year, that:

1. meet the criteria of a medical, dental, or vision expense under Code Section 213(d), and with respect to reimbursement of expenses incurred for medicine or drugs, which are treated as reimbursements for medical expenses under Code Sections 105 and 106(f);

2. will not be taken as a deduction from income on the Employee's federal income tax return in any tax year;

3. are not covered, paid, reimbursed, or reimbursable from any other source;

4. do not exceed the amount that the Employee has elected to have allotted for HCFSA reimbursement for the Plan Year, plus any amounts carried over from the prior Plan Year, less previous reimbursement of Eligible Health Care Expenses made during the Benefit Period;

5. do not include any expense incurred for qualified long-term care services as defined in Code Section 7702B(c);

6. do not include premiums for other health insurance, dental supplemental benefits, and/or vision supplemental benefits;

7. are not limited to the amount in the Covered Employee's HCFSA at the time a claim is reimbursed, but are limited to the Covered Employee's entire allotment to the HCFSA for the Plan Year plus any amounts carried over from the prior Plan Year (properly reduced for prior reimbursements during the Benefit Period).

d. Claims incurred. Eligible Health Care Expenses are reimbursable when incurred. Expenses are treated as incurred when the care that gives rise to the expense is provided, and not when the Employee is billed or pays for the medical care; however, in case of orthodontia and over-the-counter medicines and products, expenses are incurred when paid.

e. Unused allotments. Except as set forth in Section 4.22 and paragraph (f) of this Section, any amounts allotted for the Plan Year will be forfeited if a claim for reimbursement of Eligible Health Care Expenses is not postmarked or electronically transmitted by April 30 following the end of the Plan Year.

f. Carryover of unused funds. Up to five hundred dollars ($500.00) of unused allotments for the Plan Year may be carried over to the subsequent Plan Year. The amount unused for the Plan Year is the amount unused after Eligible Health Care Expenses have been reimbursed at the end of the Plan's run-out period for the Plan Year. Funds carried over will remain available to reimburse Eligible Health Care Expenses (defined with respect to the Plan Year in which they are incurred) in the subsequent Plan Year if the Covered Employee makes an allotment to an HCFSA or a LEX HCFSA for that Plan Year as described in Section 4.6.

4.3.2 Limited Purpose Health Care Flexible Spending Arrangement.

A Limited Purpose Health Care Flexible Spending Arrangement means a Limited Expense Health Care Flexible Spending Arrangement (LEX HCFSA) as described

in 4.3.2.1; a Limited Enrollment Health Care Flexible Spending Arrangement (LEN HCFSA) as described in 4.3.2.2; or a Limited Expense Limited Enrollment Health Care Flexible Spending Arrangement (LEXLEN HCFSA) as described in 4.3.2.3.

4.3.2.1 Limited Expense Health Care Flexible Spending Arrangement or LEX HCFSA.

For purposes of this Section 4.3.2.1 only, "Covered Employee" refers to a Covered Employee who is eligible to contribute to an HSA account or whose spouse is eligible to contribute to an HSA account.

a. Cash. A Covered Employee will receive cash in lieu of the optional pre-tax coverage described below, in accordance with the procedures described in Sections 4.10 and 4.11.

b. LEX HCFSA allotment. A Covered Employee may make an allotment as described in Section 4.6 and an amount equal to the allotment will be contributed by the Employer to an LEX HCFSA to pay for Limited Expense Coverage Eligible Health Care Expenses incurred during the LEX HCFSA Benefit Period.

c. LEX HCFSA Eligible Health Care Expenses. Eligible dental and vision expenses are expenses incurred during the Benefit Period and while the Employee is a Covered Employee, by the Covered Employee, or the Covered Employee's spouse, Dependent or child defined at 26 U.S.C. § 152(f)(1) who has not attained the age of 27 as of the end of the Covered Employee's taxable year that:

1. meet the criteria of a dental or vision expense under Code Section 213(d), and with respect to reimbursement of expenses incurred for medicine or drugs, which are treated as reimbursements for medical expenses under Code Sections 105 and 106(f);

2. will not be taken as a deduction from income on the Employee's federal income tax return in any tax year;

3. are not covered, paid, reimbursed, or reimbursable from any other source;

4. do not exceed the amount that the Employee has elected to have allotted for LEX HCFSA reimbursement for the Plan Year, plus any amounts carried over from the prior Plan Year (less previous reimbursement of LEX HCFSA Eligible Health Care Expenses made during the Benefit Period);

5. do not include any expense incurred for qualified long-term care services as defined in Code Section 7702B(c);

6. do not include premiums for other dental supplemental benefits, and/or vision supplemental benefits;

7. are not limited to the amount in the Covered Employee's LEX HCFSA at the time a claim is reimbursed, but are limited to the Covered Employee's entire allotment

to the LEX HCFSA for the Plan Year plus any amounts carried over from the prior Plan Year (properly reduced for prior reimbursements during the Benefit Period).

d. Claims incurred. LEX HCFSA Eligible Health Care Expenses are reimbursable when incurred. Expenses are treated as incurred when the care that gives rise to the expense is provided, and not when the Employee is billed or pays for the medical care; however, in case of orthodontia and over-the-counter medicines and products, expenses are incurred when paid.

e. Unused allotments. Except as set forth in Section 4.22 and paragraph (f) of this Section, any amounts allotted for the Plan Year will be forfeited if a claim for reimbursement of LEX HCFSA Eligible Health Care Expenses is not postmarked or electronically transmitted by April 30 following the end of the Plan Year.

f. Carryover of unused funds. Up to five hundred dollars ($500.00) of unused allotments for the Plan Year may be carried over to the subsequent Plan Year. The amount unused for the Plan Year is the amount unused after Eligible Health Care Expenses have been reimbursed at the end of the Plan's run-out period for the Plan Year. Funds carried over will remain available to reimburse Eligible Health Care Expenses (defined with respect to the Plan Year in which they are incurred) in the subsequent Plan Year if the Covered Employee makes an allotment to a LEX HCFSA or an HCFSA for that Plan Year as described in Section 4.6.

4.3.2.2 Limited Enrollment Health Care Flexible Spending Arrangement. [Reserved]

4.3.2.3 Limited Expense Limited Enrollment Health Care Flexible Spending Arrangement. [Reserved]

4.4 Dependent Care Flexible Spending Arrangement.

a. Cash. A Covered Employee will receive cash in lieu of the optional pre-tax coverage described below, in accordance with the procedures described in Sections 4.10 and 4.11.

b. Dependent Care Flexible Spending Arrangement allotment. A Covered Employee may make an allotment as described in Section 4.6 and an amount equal to the allotment will be contributed by the Employer to a DCFSA to pay for Eligible Dependent Care Expenses incurred during the DCFSA Benefit Period.

c. Eligible Dependent Care Expenses means employment-related expenses under Code Section 21(b)(2) incurred for the care of a Qualifying Dependent and household services necessary to enable the Covered Employee and spouse, if any, to be gainfully employed, look for employment, or attend school full-time. Eligible Dependent Care Expenses must be incurred while the Employee is a Covered Employee or after separation from service during the Benefit Period, and:

1. are limited to amounts paid for services rendered in the Covered Employee's home or amounts paid for services rendered outside of the Covered Employee's home only if they are for the care of a Qualifying Dependent: (i) defined in Section

2.37.a, or (ii) defined in Section 2.37.b and who regularly spends at least eight hours each day in the Covered Employee's household. Services rendered in a dependent care center as defined in Code Section 21(b)(2)(D) must satisfy the requirements of Code Section 21(b)(2)(C);

2. are limited to the amount the Covered Employee has allotted for reimbursement of Eligible Dependent Care Expenses for the Plan Year less any prior reimbursement of Eligible Dependent Care Expenses during the Benefit Period;

3. are limited to the amount in the Covered Employee's DCFSA at the time a claim is reimbursed; and

4. are not covered, paid, reimbursed, or reimbursable from any other source.

d. Claims incurred. Eligible Dependent Care Expenses are reimbursable when incurred. Expenses are treated as incurred when the services that give rise to the dependent care expense are provided, and not when they are billed for or paid for; in the case of au pair fees, or fees for a child care placement agency, up-front fees paid to an organization to secure an au pair or child care provider are reimbursable proportionately over the duration of the agreement to employ the au pair or child care provider.

e. Unused allotments. Any amounts allotted for the Plan Year will be forfeited if a claim for reimbursement of Eligible Dependent Care Expenses is not postmarked by April 30 following the end of the Plan Year.

4.5 Health Savings Account "HSA."

a. A Covered Employee who is an eligible individual pursuant to Code Section 223 and IRS guidance shall establish an HSA with an HSA Trustee or Custodian to account for allotments, contributions or other payments used to fund the HSA.

b. Each Covered Employee's HSA will be credited with the sum of:

1. amounts allotted as pre-tax HSA allotments as provided in paragraph (c) of this Section by the Covered Employee, if any;

2. premium pass-through amounts, as defined in paragraph (d) of this Section, if any; and

3. other contributions permitted under Code Section 223 and other IRS guidance.

The Covered Employee's total contribution to an HSA for the Plan Year and eligibility for monthly contributions during a plan year are limited in accordance with Code and IRS guidance.

c. Allotment Election

1. Cash. A Covered Employee will receive cash in lieu of the optional pre-tax HSA unless the allotment is in accordance with Section 4.5.c.2.

2. HSA Allotment.

a. A Covered Employee who is an HSA holder may make an allotment pursuant to Section 4.6 and an amount equal to the allotment will be contributed by the Employer to the Covered Employee's HSA.

b. A Covered Employee who is an HSA holder may revoke the allotment election made pursuant to Section 4.6 using the HSA revocation procedure described in Section 4.5.e.

c. A Covered Employee who is no longer an eligible individual pursuant to Code Section 223 may not contribute allotments to an HSA account, and must revoke the allotment election made as described above.

d. If a Covered Employee who is an HSA holder is on leave without pay (LWOP), or has insufficient pay, the Employer will not contribute the Covered Employee's allotments during the period of LWOP or insufficient pay. The Covered Employee's allotments that would otherwise be made during the period of LWOP or insufficient pay may be prepaid using the allotment election procedure as described in Section 4.5.c. as permitted by the Employer and its payroll provider or the Covered Employee may pay directly on an after-tax basis, as long as the annual limit is not exceeded.

d. Premium Pass-Through. For purposes of this section, premium pass-through amounts are amounts that a Medical Plan that is an HDHP contributes to an HSA.

e. HSA Election Procedure, Modifications and Revocations. An election to make, change, or revoke an HSA allotment must be made in a form acceptable to the Employer at a time the Employer or its payroll provider is able to effect a pre-tax allotment.

HSA allotments are not subject to a mandatory 12-month period of coverage. A Covered Employee who elects to make HSA allotments may modify the allotment at any time as long as the change is prospective and in accordance with the administrative procedures established by the Covered Employee's payroll provider. Section 4.18 does not apply.

The HSA allotment election continues into a subsequent Plan Year unless or until the Covered Employee modifies or revokes that allotment election.

f. No Forfeiture. Any balance that may remain in a Covered Employee's HSA at the end of a Plan Year is automatically carried forward in the account. No HSA account balance is subject to forfeiture.

g. These rules apply to HSAs notwithstanding Section 4.16 or any other provisions in this plan.

4.6 **Allotments.** Reduction of pay for coverage options elected under Section 4.1 and Section 4.1.1 will occur via an allotment to the agency under 5 U.S.C. 5525, or its

functional equivalent, and any applicable regulations. The allotment for any pay date may not exceed the amount of the Covered Employee's pay available for allotment for that pay period. Allotments are deemed to be made voluntarily.

a. Medical Plan. For a Covered Employee who elects pre-tax Medical Plan coverage under Sections 4.2 and 4.7, pay will be reduced by the amount equal to the Covered Employee's share of his or her Medical Plan premium. A Covered Employee must elect an HDHP to be eligible to contribute to an HSA.

b. Dental Plan. For a Covered Employee who elects Dental Plan coverage under Sections 4.2 and 4.9, pay will be reduced by the amount equal to the Covered Employee's Dental Plan premium.

c. Vision Plan. For a Covered Employee who elects Vision Plan coverage under Sections 4.2 and 4.9, pay will be reduced by the amount equal to the Covered Employee's Vision Plan premium.

d. HCFSA. For a Covered Employee who elects pre-tax contributions to an HCFSA under Sections 4.3.1 or 4.3.2 and 4.10, pay will be reduced by the amount elected for the year, apportioned substantially equally among the remaining pay periods for such year. A Covered Employee may elect an HCFSA allotment for a Plan Year of an amount within the limits stated in the Summary of Benefits.

e. DCFSA. For a Covered Employee who elects pre-tax contributions to a DCFSA under Sections 4.4 and 4.10, pay will be reduced by the amount elected for the year, apportioned substantially equally among the remaining pay periods for such year. A Covered Employee may elect a DCFSA allotment for a Plan Year of an amount within the limits stated in the Summary of Benefits.

f. HSA. For a Covered Employee who elects pre-tax contributions to an HSA under Section 4.5.c.2, pay will be reduced by the amount elected per pay period.

4.7 Cash Election Procedure for Employees Covered under a Medical Plan.

a. Initial Plan Year election procedure. A Covered Employee who is enrolled in a Medical Plan may elect to receive cash in lieu of coverage as described in Section 4.2 and may obtain an election form from the Employer. The Covered Employee must obtain, complete and return this election form to the agency human resources office on or before the day designated by the Employer, but in no event later than the day before the first day of the first pay period that begins on or after the Effective Date. The election shall be effective as of the first day of the first pay period that begins on or after the Effective Date.

b. New Covered Employee election procedure. As soon as practicable after an individual becomes a Covered Employee under Section 3.1 or 3.3, the Employer shall have available the election form described in Section 4.7.a. If the Covered Employee enrolls in a Medical Plan and wishes to elect the cash option described in Section 4.2.d for the balance of the Plan Year, the Covered Employee must obtain, complete and return this election form to the agency human resources office together with the Medical Plan enrollment form during the period permitted for new enrollment in the FEHB Program. The election will be effective prospectively as of the first day of the first pay period for which Medical Plan coverage becomes effective.

c. Reemployed Annuitant election procedure. If the new Covered Employee is a Reemployed Annuitant who is already enrolled in a Medical Plan as an annuitant, and that Covered Employee wishes to elect the cash option described in Section 4.2.d, the Covered Employee must obtain, complete and return this election form to the agency human resources office within 60 days of becoming a Covered Employee under 3.1. The election will be effective as of the first day of the first pay period following the Employer's receipt of the Form.

d. Open season election procedure. At the time prescribed for the annual open season for the FEHB Program, a Covered Employee who enrolls or remains enrolled in a Medical Plan may elect to receive cash in lieu of coverage as described in Section 4.2. The Employer shall have available the written election form described in Section 4.7.a. The Covered Employee must obtain, complete and return this election form to the agency human resources office on or before the last day of the open season. The election shall be effective on the same day as all FEHB open season changes. If, for any reason, OPM conducts a special open season, the above procedure shall apply, except that the election shall be effective as of the date that OPM shall prescribe.

e. Change in status election procedure. A Covered Employee may not revoke an election during a Plan Year except in the case of a change in status described in Section 4.16.

4.8 Failure to Obtain and Return Cash Election Form for Employees Covered under a Medical Plan.

a. Initial Plan Year. A Covered Employee's failure to return a completed election form to the Employer on or before the Effective Date for the Initial Plan Year shall

constitute an election of pre-tax premium coverage under Section 4.2.e.

b. New Covered Employees and Reemployed Annuitants. A Covered Employee's failure to obtain and return a completed election form to the Employer on or before the date described in Section 4.7 for the Plan Year in which he or she becomes a Covered Employee, shall constitute an election of pre-tax premium coverage under Section 4.2.e.

c. Subsequent Plan Years. A Covered Employee's failure to obtain and return a completed election form to the Employer on or before the date described in Section 4.7.d, for any subsequent Plan Year shall constitute a re-election of the same option as was in effect for the Covered Employee just prior to the end of the preceding Plan Year. If the Covered Employee's prior Plan Year election was pre-tax premium coverage, failure to return a completed election form to the Employer on or before the date described in Section 4.7.d shall also constitute election of an allotment under Section 4.6.

4.9 Election Procedures under a Dental Plan and/or a Vision Plan.

a. A Covered Employee’s election to enroll in a Dental Plan and/or a Vision Plan constitutes an election of pre-tax premium coverage under Section 4.2.f and/or 4.2.g.

b. Initial Plan Year for Dental Plan and Vision Plan election procedure. Prior to the Initial Effective Date for Dental Plan and Vision Plan, a Covered Employee may elect to allot on a pre-tax basis, an amount equal to the premium required to purchase coverage under a Dental Plan and/or Vision Plan. The Covered Employee must obtain an election Form for this purpose from OPM or its Plan Agent. The Covered Employee must complete and return this election Form to OPM or its Plan Agent on or before the day designated, but in no event later than the Initial Effective Date for Dental Plan and Vision Plan except that a Covered Employee who is not actively at work at any time during the official enrollment period for the Initial Plan Year for Dental Plan and Vision Plan may enroll on the first date he or she could have made an election as determined by the OPM or its Plan Agent The election will be effective prospectively as of the first day of the pay period that begins following acceptance of the election Form by OPM or its Plan Agent, but no earlier than the Initial Effective Date for Dental Plan and Vision Plan. Elections made during the Initial Plan Year for Dental Plan and Vision Plan remain in effect until the end of the following Plan Year.

c. New Covered Employee election procedure. As soon as practicable after an individual becomes a Covered Employee under Section 3.1 or 3.3, OPM or its Plan Agent shall make available the election Form described in Section 4.9.b. If the Covered Employee wishes to elect coverage under the Dental Plan and/or Vision Plan for the balance of the Plan Year, the Covered Employee must complete the Form and return it to OPM or its Plan Agent on or before the day designated by the Employer under Section 4.9.b for pre-tax coverage under a Dental Plan and/or Vision Plan. The election will be effective prospectively as of the first day of the pay period that begins following acceptance of the election Form by OPM or its Plan Agent.

d. Reemployed Annuitant election procedure. Reemployed Annuitants with a break in service of at least 30 days will be treated as new Covered Employees for purposes of Dental Plan and/or Vision Plan elections. For Reemployed Annuitants with a break in service of less than 30 days, Dental Plan and/or Vision Plan elections previously in effect will be automatically reinstated as provided in Section 4.16.f.

e. Open season election procedure. At the time prescribed for the annual open season, a Covered Employee may enroll, remain enrolled, or change his or her enrollment in a Dental Plan and/or a Vision Plan. OPM or its Plan Agent shall make available the election Form described in Section 4.9(b). The Covered Employee must complete and submit the Form to OPM or its Plan Agent on or before the last day of the open season. The election shall be effective on January 1 of the next Plan Year. If, for any reason, OPM conducts a special open season, the above procedure shall apply, except that the election shall be effective as of the date that OPM shall prescribe.

f. Subsequent Plan Years. A Covered Employee's failure to obtain and return a completed election Form to OPM or its Plan Agent on or before the date described in Section 4.9.e, for any subsequent Plan Year shall constitute a re-election of the same option as was in effect for the Covered Employee just prior to the end of the preceding Plan Year.

g. Absentee/belated enrollment. If a Covered Employee is unable to elect coverage under the Dental Plan and/or Vision Plan during an annual open season for the FEHB Program for reasons outside of his or her control, the Covered Employee may make a belated enrollment within 30 days of the first date he or she could have made an election as determined by OPM or its Plan Agent.

h. Change in status election procedure. A Covered Employee may not revoke an election during a Plan Year except in the case of a change in status described in Section 4.16.

4.10 Election Procedures under a Flexible Spending Arrangement.

a. New Covered Employee election procedure. As soon as practicable after an individual becomes a Covered Employee under Section 3.1 or 3.3, the Employee may elect to allot an amount in lieu of pay on a pre-tax basis to an FSA, in an amount not to exceed the limits described in Section 4.6.d for the HCFSA and Section 4.6.e for the DCFSA. The Covered Employee may obtain an election Form for this purpose from OPM or its Plan Agent. If the Covered Employee wishes to elect a pre-tax allotment to a Flexible Spending Arrangement for the balance of the Plan Year, the Covered Employee must complete the Form and submit it to OPM or its Plan Agent on or before the day designated by the Employer under Section 4.7.b for pre-tax coverage under a Medical Plan. The election will be effective prospectively as of the day following acceptance of the election Form by OPM or its Plan Agent.

1. For purposes of HCFSA and LEX HCFSA only, OPM or its Plan Agent will not accept new elections after September 30 of any Plan Year.

b. Reemployed Annuitant election procedure. Reemployed Annuitants with a break in

service of at least 60 days will be treated as new Covered Employees for purposes of HCFSA and DCFSA elections. For Reemployed Annuitants with a break in service of less than 60 days, HCFSA and DCFSA elections previously in effect will be automatically reinstated as provided in Section 4.16.e.

c. Open season election procedure. At the time prescribed for the annual open season for the FEHB Program, a Covered Employee may elect to make a pre-tax allotment to an FSA, in an amount not to exceed the limits described in the Summary of Benefits. OPM or its Plan Agent shall make available the written election Form described in Section 4.10.a. The Covered Employee must complete and submit the Form to OPM or its Plan Agent on or before the last day of the open season. The election shall be effective on January 1 of the next Plan Year. If, for any reason, OPM conducts a special FEHB Program open season, special Dental open season, or special Vision open season, OPM may also conduct a special open season for the HCFSA. In such case, the above procedure shall apply, except that the election shall be effective as of the date that OPM shall prescribe.

d. Absentee/belated enrollment. If a Covered Employee is unable to make a pre-tax allotment to an FSA during an annual open season or upon first becoming a Covered Employee for the FEHB Program for reasons outside of his or her control, the Covered Employee may make a belated enrollment within 30 days of the first date he or she could have made an election as determined by OPM or its Plan Agent.

1. OPM or its Plan Agent will not accept new elections after September 30 of any Plan Year.

e. Change in status election procedure. A Covered Employee may not revoke an election during a Plan Year except in the case of a change in status described in Section 4.16.

1. OPM or its Plan Agent will not accept change in status to increase an election after September 30 of any Plan Year.

4.11 Failure to Return Flexible Spending Arrangement Election Form. A Covered Employee's failure to return a completed election Form to OPM or its Plan Agent on or before:

a. the Effective Date for the FSA Initial Plan Year;

b. the date described in Section 4.10.a for the Plan Year in which he or she becomes a Covered Employee; or

c. the date described in Section 4.10.c, for any subsequent Plan Year;

shall constitute an election to receive cash in lieu of Flexible Spending Arrangement Benefits.

4.12 Reserved

4.13 Reserved

4.14 Reserved

4.15 Reserved

4.16 Irrevocability of Election by Covered Employee during the Plan Year.

a. A Covered Employee may not make an election change under the Plan (including an election made through inaction under Section 4.8) during the Plan Year, except as provided in Section 4.16.b.

b. A Covered Employee may revoke an election and file a new election for the balance of a Plan Year if both the revocation and the new election are: (1) consistent with the statutes and regulations applicable to and the terms of the Covered Employee's Medical Plan, Dental Plan, Vision Plan, HCFSA or DCFSA; and (2) made on account of and correspond with a qualifying life event.

For this purpose, a qualifying life event means an event that may permit an election change during a Plan Year pursuant to 26 CFR. §1.125-4 such as: a change in marital status, such as a marriage, death of a spouse, divorce, legal separation or annulment; a change in the Covered Employee's number of dependents or non-dependent children under age 27 as of the end of the Covered Employee's taxable year, such as by birth, adoption, death, placement for adoption; or becoming newly eligible for health plan or HCFSA coverage or eligible for coverage beyond the date on which the child would otherwise have lost coverage; a change in employment status that alters the Covered Employee's eligibility under the Medical Plan, such as termination of employment, a significant curtailment in coverage or elimination or addition of a new benefit package option under the Medical Plan; a significant change in the coverage or cost of coverage of a spouse or dependent or non-dependent child under age 27 as of the end of the Covered Employee's taxable year under a plan of the employer of the spouse, dependent, or non-dependent child. For purposes of pre-tax Medical Plan coverage the Employer will determine if an event permits an election change during a Plan Year. For purposes of the Dental Plan, Vision Plan and/or FSA coverage, OPM or its Plan Agent will determine if an event permits an election change during a Plan Year.

c. In order to revoke an election and/or file a new election under Section 4.16.b, a Covered Employee must obtain and complete the applicable election Form described in Section 4.7.a for the Medical Plan, Section 4.9.b for the Dental Plan and/or Vision Plan, or Section 4.10.a for the FSA, and return the appropriate form on or before the date specified by OPM to OPM or its Plan Agent. This revocation and new election will be effective at such time as OPM prescribes, but not earlier than the first day of the first pay period beginning after the revocation and new election.

d. No Covered Employee will be allowed to reduce his or her election for an HCFSA or DCFSA to a point where the total allotment for the Plan Year for such benefit is less than the amount already reimbursed for that Plan Year. In addition, any change in an election affecting the Covered Employee's annual allotments to the HCFSA or DCFSA pursuant to this section also will change the Covered Employee's benefits for the period of coverage remaining in the Plan Year. The Covered Employee's

benefits following an election change will be calculated by adding any balance (including a negative balance) remaining in the Covered Employee's HCFSA or DCFSA as of the end of the portion of the Plan Year immediately preceding the change in election, to the total allotments scheduled to be made by the Covered Employee during the remainder of such Plan Year to each account, respectively.

e. If a former Covered Employee whose elections have automatically terminated under Section 4.19 again becomes a Covered Employee:

(1) within 60 days of ceasing to be a Covered Employee; and
(2) before the end of the same Plan Year

the HCFSA and DCFSA elections previously in effect for the Covered Employee will automatically be reinstated for the balance of the Plan Year, unless:

(1) there has been an intervening event that would permit an election change and the election right has been exercised, or
(2) the Covered Employee subsequently qualifies to make an election change under paragraph (b) of this Section.

f. If a former Covered Employee whose elections have automatically terminated under Section 4.19 again becomes a Covered Employee:

(1) within 30 days of ceasing to be a Covered Employee; and
(2) before the end of the same Plan Year

the Dental Plan and/or Vision Plan elections previously in effect for the Covered Employee will automatically be reinstated for the balance of the Plan Year, unless:

(1) there has been an intervening event that would permit an election change and the election right has been exercised, or
(2) the Covered Employee subsequently qualifies to make an election change under paragraph (b) of this Section.

4.17 Reserved

4.18 Adjustment of Allotments.

a. Change in cost of Medical Plan coverage. If the cost of coverage provided by a Medical Plan increases or decreases during a Plan Year, a Covered Employee's allotment will increase or decrease accordingly.

b. Change in cost of Dental Plan and/or Vision Plan coverage. If the cost of coverage provided by a Dental Plan and/or Vision Plan increases or decreases during a Plan Year, a Covered Employee's allotment will increase or decrease accordingly.

c. Adjustment to highly compensated employee allotments. If OPM determines that the Plan will fail to satisfy a nondiscrimination requirement imposed by the Code, OPM may modify or revoke elections made by key employees or highly compensated individuals or employees, as defined under Code Section 125 without the consent of

such Covered Employees, or take any other appropriate action.

4.19 **Automatic Termination of Election.** Any election made under this Plan (including an election made through inaction under Section 4.8) automatically terminates when the Covered Employee stops being a Covered Employee in the Plan, even though coverage or benefits under the Medical Plan may continue if and to the extent provided by the Medical Plan or an election to receive Temporary Continuation of Coverage (TCC).

4.20 **Failure to Pay Premiums.** Coverage and benefits under a Medical Plan, Dental Plan and/or Vision Plan will terminate in accordance with the terms of the Medical Plan, Dental Plan and/or Vision Plan if a Covered Employee fails to pay his or her required premium, through allotment or otherwise. However, a Covered Employee may not make an election change under the Plan during a Plan Year except as permitted under Section 4.16.

4.21 **Leave Without Pay.**

a. For Medical Plan. If a Covered Employee is on leave without pay (LWOP) and continues Medical Plan coverage, the Employer will contribute the Covered Employee's share of premiums during the LWOP period that would otherwise have been treated as allotments under Section 4.6 and the Covered Employee will reimburse the Employer by prior allotment or catch-up allotment as prescribed by OPM regulations. Alternatively, the Covered Employee may pay Medical Plan premiums directly on an after-tax basis, as permitted by the Plan.

b. For Dental Plan and/or Vision Plan. If a Covered Employee is on leave without pay (LWOP) or any non-pay status, the Employer will not contribute the Covered Employee's allotments during the LWOP/non-pay period. The Covered Employee's allotments that would otherwise be made during the LWOP period may be prepaid or the Covered Employee may pay premiums directly on an after-tax basis, as permitted by OPM and the Employer.

c. For FSAs. If a Covered Employee is on leave without pay (LWOP), the Employer will not contribute the Covered Employee's allotments during the leave without pay period. The Covered Employee's allotments that would otherwise be made during the LWOP period may be prepaid or may be made through catch-up allotment as prescribed by OPM regulations or permitted by the Employer.

4.22 **Qualified Reservist Distributions Under the HCFSA**

a. QRD Request and Effective Date. Effective January 1, 2009, a Qualified Reservist who meets the requirements of this Section 4.22 may request a Qualified Reservist Distribution (QRD) to avoid forfeiting unused allotments remaining in his or her HCFSA pursuant to Section 4.3.1(e) or LEX HCFSA pursuant to Section 4.3.2.1(e).

b. Required Length of Order or Call to Active Duty. Covered Employees who are also Qualified Reservists ordered or called to active duty on or after June 18, 2008, for at least 180 days, or for an indefinite period, may request one Qualified Reservist Distribution (QRD) during a Plan Year. An order or call to active duty of less than

180 days' duration that is supplemented by subsequent calls or orders to increase the total period of active duty to 180 or more days will render a Qualified Reservist eligible for a QRD.

c. Orders Before June 18, 2008. A Qualified Reservist ordered or called to active duty before June 18, 2008 is eligible for a QRD if the Qualified Reservists' period of active duty continues after June 18, 2008, and it otherwise meets the durational requirements outlined in Section 4.22(b), above.

d. Timing of QRD Request. A request for a QRD must be made no earlier than the date of the order or call to active duty and no later than the last day of the Grace Period of the Plan Year that includes the date of the order or call to active duty.

e. Form of QRD Request. To qualify to receive a QRD, the Qualified Reservist must submit a copy of the order(s) or call(s) to active duty to the Plan Agent, accompanied by a written QRD request, specifying the amount desired, on the Form adopted by OPM for this purpose.

f. Review of QRD Request. OPM or its Plan Agent will review all QRD requests on a uniform, non-discriminatory basis and will pay any eligible QRD request within 60 days of receipt of the request.

g. Amount of QRD Request. A Qualified Reservist may request the balance in the Qualified Reservist's HCFSA during the Plan Year as of the date of the request, calculated as follows: the amount contributed to the HCFSA as of the date of the QRD request minus Eligible Health Care Expenses claimed as of the date of the QRD request. After the QRD is requested, the Qualified Reservist's right to submit claims is terminated for the remainder of the Plan Year of the QRD.

h. QRD Request During a Grace Period. If a QRD is requested during the Grace Period for a Plan Year, the distribution may be made for the balance in the HCFSA for the Plan Year of the Grace Period, the current Plan Year, or both. If the Qualified Reservist fails to designate the Plan Year for which a QRD is requested, the distribution will be made for the Plan Year of the Grace Period.

i. Claims Submission Not Permitted On or After Date of QRD Request. A Qualified Reservist has until the date of the request to submit claims for reimbursement of Eligible Health Care Expenses incurred before the date a QRD is requested. Qualified Reservists may not submit claims for reimbursement of Eligible Health Care Expenses incurred on or after the date of the QRD request.

j. When a QRD Will Not be Made. A QRD will not be made with respect to amounts: (1) forfeited on or before June 18, 2008, (2) attributable to a prior Plan Year, or (3) not attributable to the HCFSA.

k. QRD is Taxable Income. Amounts distributed under a QRD are considered taxable income and will be reported on the Covered Employee's Form W-2 for the year in which the QRD is paid.

Article 5. PAYMENT OF CLAIMS FOR FLEXIBLE SPENDING ARRANGEMENTS.

5.1 Claims Reimbursement for Eligible Health Care Expenses.

a. To make a claim for reimbursement of Eligible Health Care Expenses, the Covered Employee must submit a statement to OPM or its Plan Agent on an appropriate form adopted by OPM for this plan. The Covered Employee must provide the following information as requested by the Plan Agent:

1. written evidence from an independent third party stating the services rendered or product purchased and the amount of the health care expense that has been incurred;

2. the Covered Employee's certification that the claimed expenses are Eligible Health Care Expenses; and

3. any other information OPM and its Plan Agent may find necessary.

b. OPM and its Plan Agent reserve the right to verify all claimed expenses prior to reimbursement and to reimburse only those amounts that they determine are Eligible Health Care Expenses.

c. All claims for reimbursement not filed during the Benefit Period must be postmarked or electronically transmitted by April 30 following the end of the Plan Year in which the expense was incurred.

d. On or before January 31 of each year, the Plan Agent will furnish to each Covered Employee who elected a HCFSA for the prior Plan Year, a statement showing the amount of health care expenses reimbursed during the Plan Year for Eligible Health Care Expenses incurred by the Covered Employee.

e. Claim reimbursements as described in Section 5.1.a do not apply to HSAs.

5.2 Claims Reimbursement for Eligible Dependent Care Expenses.

a. To make a claim for reimbursement of Eligible Dependent Care Expenses, the Covered Employee must submit a statement to OPM or its Plan Agent on an appropriate form adopted by OPM for this plan. The Covered Employee must provide the following information as requested by the Plan Agent:

1. information necessary to substantiate that the dependent or dependents are Qualifying Dependent(s), such as the age of the dependent or a statement as to the physical or mental capacity of the dependent;

2. written evidence from an independent third party stating that the expenses have been incurred, a description of the services and where the services were performed, the amount of the expense, and any other information OPM and its Plan Agent may find necessary;

3. the relationship to the Covered Employee, if any, of the person performing the

services;

if the services are to be performed in a dependent care center, a statement that the dependent care center meets the requirements of Code Section 21;

4. if the Covered Employee is married:

a. the spouse's salary or wages, if he or she is employed;

b. if the spouse is not employed, a statement that he or she is incapacitated or is a student within the meaning of Code Section 21(d)(2);

5. the Covered Employee's certification that the expenses are Eligible Dependent Care Expenses, are necessary to enable the Covered Employee and spouse, if any, to be gainfully employed, looking for work, or attending school full time, and have not been reimbursed and are not reimbursable under any other plan or by any other entity.

b. OPM and its Plan Agent reserve the right to verify all claimed expenses prior to reimbursement and to reimburse only those amounts that they determine are Eligible Dependent Care Expenses.

c. All claims for reimbursement must be postmarked or electronically transmitted by April 30 following the end of the Benefit Period in which the expense was incurred.

d. On or before January 31 of each year, the Plan Agent will furnish to each Covered Employee who elected a DCFSA for the prior Plan Year, a statement showing the amount of dependent care assistance paid during the Plan Year for Eligible Dependent Care Expenses incurred by the Covered Employee.

5.3 **Payment of Claims.** OPM or its Plan Agent will pay properly submitted claims for reimbursement at least monthly or when the total amount of the claim to be submitted is at least a specified, reasonable, minimum amount.

5.4 **Reserved.**

5.5 **Expenses.** All administrative expenses, including overpayments, incurred under the Plan will be paid from one or more of the following Plan assets:

a. Forfeitures of FSA coverage under the Plan; or

b. Investment earnings credited on Plan assets pending payment against valid claims; or

c. Contributions by the Employers of Covered Employees.

5.6 **Minimum Reimbursement Amount.** A minimum reimbursement amount from an FSA may be imposed by OPM as provided in the Summary of Benefits.

5.7 **Repayment of Unsubstantiated Reimbursements.** If a Covered Employee receives payments under this Plan that exceed the amount of Eligible Health Care Expenses or

Eligible Dependent Care Expenses substantiated by the Covered Employee during the Plan Year, OPM or its Plan Agent will notify the Covered Employee in writing of any such excess amount, and the Covered Employee will be required to repay that excess amount to the Plan within 60 days after receiving the notice.

5.8 **Claims Appeal Process.** A Covered Employee has the right to appeal a claim for benefits that has been denied in whole or in part by written request to the Plan Agent for reconsideration. If after reconsideration the claim is not paid in full, the Covered Employee may appeal in writing to the Plan Agent for further review of the denied claim using procedures outlined by the Plan Agent. OPM retains the authority to finally resolve all disputed claims through a binding arbitration process as follows. If the Covered Employee's appeal to the Plan Agent is denied in whole or in part, OPM and the Plan Agent will select an arbitrator from a panel of arbitrators pre-approved by OPM and the Plan Agent. The mutually selected arbitrator will review the denied claim and make a decision whether or not the claim should be paid. The arbitrator's decision will be binding on the Covered Employee and the Employer.

5.9 **Coordination of Benefits under HCFSA.** An HCFSA is not a group health plan for coordination of benefits purposes. Because an HCFSA is intended to reimburse benefits only for otherwise unreimbursable medical expenses, its benefits may not be taken into account when determining benefits payable under any other plan.

5.10 **Post-Mortem Payments.** If a Covered Employee dies after incurring an Eligible Health Care Expense but before filing a claim or receiving reimbursement, the deceased Covered Employee's surviving spouse or dependents, or if none, his or her estate, may submit a claim or receive payment, as appropriate. The Plan Agent will retain the benefits without liability for any interest until the Plan Agent determines the proper person(s) to pay.

5.11 **Inability to Locate Payee.** If after reasonable efforts the Plan Agent cannot ascertain the identity or whereabouts of the proper person(s) to whom payment is due under the Plan, the payment will be forfeited.

5.12 **Non-Alienation of Benefits.** Except as expressly provided by OPM, no benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so will be void. No benefit under the Plan will in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

5.13 **Electronic Fund Transfers.** OPM, in its sole discretion, is authorized to require a Covered Employee who has elected a Flexible Spending Arrangement under Section 4.10 to execute an Electronic Fund Transfer (EFT) agreement with their financial institution to allow for the electronic reimbursement of Eligible Health Care Expenses or Eligible Dependent Care Expenses.

Article 6. ADMINISTRATION OF PLAN.

6.1 **Plan Administration.** OPM will administer the Plan according to its terms and subject to applicable law, for the exclusive benefit of persons entitled to participate in the Plan, without discrimination among them. In addition to all other powers provided by this Plan, OPM has authority to:

a. Make and enforce rules and regulations as OPM deems necessary or proper to efficiently administer the Plan;

b. Interpret the Plan in good faith, and OPM's interpretations will be final and conclusive on all persons claiming benefits under the Plan;

c. Decide all questions concerning the Plan, the criteria for eligibility to participate in the Plan, and accounting requirements under the Plan;

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

e. Appoint agents, counsel, accountants, consultants and other persons as needed to help administer the Plan; and

f. Allocate and delegate, in writing, OPM's responsibilities under the Plan and to designate other persons or entities to carry out any of its responsibilities under the Plan.

g. Notwithstanding the foregoing, any claim that arises under a Medical Plan, Dental Plan and/or Vision Plan is not subject to review under this Plan.

6.2 **Eligibility Decisions.** The Employer has authority to determine a Covered Employee's eligibility under the Plan, in accordance with criteria determined by OPM.

6.3 **Accounting.** OPM or its Plan Agent will maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Eligible Health Care Expenses or Eligible Dependent Care Expenses on behalf of any Covered Employee. FSA records will be maintained for accounting purposes only and will not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the FSAs.

6.4 **Audit and Review of Plan Agent.** OPM has the right to audit the records and operations of the Plan Agent and to review any decisions made by the Plan Agent on behalf of the Plan.

6.5 **Examination of Records.** The Employer will make available to each Covered Employee such Plan records that it has in its possession or control that pertain to the Covered Employee, for examination during normal business hours.

6.6 **Reliance on Tables, etc.** In administering the Plan, OPM may 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 Medical Plan, Dental Plan, Vision Plan, Plan Agent, or by accountants, counsel or other experts OPM employs or engages.

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

6.8 **Reserved**

Article 7. AMENDMENT OR TERMINATION OF PLAN.

OPM may amend or terminate the Plan at any time.

Article 8. MISCELLANEOUS PROVISIONS.

8.1 **Information to be Furnished.** Covered Employees must provide the Employer and OPM with information that may reasonably be requested from time to time to administer the Plan.

8.2 **Limitation of Rights.** This Plan and the benefits it offers do not provide any additional rights to Covered Employees.

8.3 **Governing Law.** This Plan shall be construed, administered and enforced according to the laws of the United States of America.

8.4 **Adoption Agreements.** An Employer of an Employee may adopt this Plan by signing an adoption agreement specified by OPM. The Employer will become an Adopting Employer under the Plan upon OPM's acceptance of the adoption agreement.

8.5 **Transition Relief.** For the Plan Year ending December 31, 2005, this Plan is hereby amended to provide eligibility to contribute to an HSA during the Grace Period in accordance with provisions of transitional relief set forth in IRS Notice 2005-86.

8.6 **Severability.** Should any part of this Plan be rendered or declared invalid by Federal statute or regulations, or a court of competent jurisdiction, such invalidation of such part or portion of this Plan should not invalidate the remaining portions thereof, and they shall remain in full force and effect.

The Director of the Office of Personnel Management adopts this Plan for the Executive Branch of the United States Government.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

By:_____ Date: _____
Katherine Archuleta
Director