2026 | SECTION 125
CAFETERIA PLAN DOCUMENT

Core Documents

CITY OF LUVERNE
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

PLAN PURPOSE

The City of Luverne Flexible Benefits Plan (the "Plan") is a benefit program that allows you to use pre-tax benefit dollars through payroll deduction to pay for insurance premium(s), HSA contributions, unreimbursed medical expenses, and dependent care expenses. Section 125 of the Internal Revenue Code permits City of Luverne to offer you the opportunity to participate in designing your own personalized benefit plan on a tax-favored (pretax) basis. This Summary does not describe every detail of the Flexible Benefits Plan. If there is a conflict between the Plan Document and the Summary, the Plan Document will control.

WHO IS ELIGIBLE TO ENROLL IN THE PLAN

If you are an Employee regularly scheduled to work 40 or more hours per week for City of Luverne ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

For purposes of the Premium Only Module your Spouse or Dependent(s) can only receive benefits through the Plan if they are named on your qualifying policy. Your Spouse or Dependent(s) cannot participate in the Plan independently.

Self-employed individuals are not eligible to participate in the Plan, however C Corporation owners who are also W2 Employees can participate.

HOW TO ENROLL

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made during the month preceding the Plan Year for which it will be in effect. Each year, City of Luverne will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your salary reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible Employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent permissible (your normal paycheck will not be voluntarily reduced). If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, then you will be able to maintain the medical and dental

benefit options, if any, that you elected for the prior year, but will not be eligible to participate in either the Health FSA or the Dependent Care Assistance Plan (DCAP) Spending Account.

You may build a completely new plan each year. Keep in mind that your choices are in effect for the entire Plan Year. Generally, you cannot change the elections you have made after the beginning of the Plan Year.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the next Plan Year.

WHEN YOU ARE ELIGIBLE TO ENROLL

You may enroll in the Plan effective on the first day of the month following date of hire as an Eligible Employee.

SCHEDULE OF FLEXIBLE BENEFITS

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the Spending Accounts are provided by City of Luverne on the enrollment form and outlined in Schedule B and Schedule D of this Summary Plan Description.

The benefits from which you may choose include:

- medical plan(s) outlined in Schedule A
- Health Savings Account (HSA) contributions
- two different spending accounts:
  - a Health Flexible Spending Account (Health FSA)
  - a Dependent Care Assistance Plan Flexible Spending Account (DCAP)

Each benefit under the Flexible Benefits Plan has separate rules governing benefits and plan administration. These rules are explained in more detail in the plan documents that have been prepared solely for the purpose of each particular benefit. A copy of all this information is available from Jill Wolf at the Company.

OPTIONAL BENEFITS

Briefly, the Optional Benefits from which you may choose are as follows:

1. Health Insurance Plan(s)

You may purchase the health insurance coverage for yourself and your family through the Flexible Benefits Plan. You may pay for this coverage using pretax dollars that are automatically deducted per pay period. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

2. Health Savings Account (HSA) Module

An Eligible Employee can elect to participate in the HSA Module by electing to make HSA Contributions on a pre-tax Salary Reduction basis. The HSA is established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). Such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

The annual Contribution for your HSA Benefits is equal to the annual benefit amount elected by you (for example, if the maximum $8,300 annual benefit amount is elected, then the annual contribution amount is also $8,300). In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made.

An additional catch-up Contribution ($1,000 each year) may be made for HSA owners who are age 55 or older. In addition, the maximum annual Contribution shall be reduced by any matching (or other) Employer Contribution made on the Participant's behalf, other than pre-tax Salary Reductions made under the Plan.

The HSA is not an Employer-sponsored Employee benefit plan; it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Employee, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions - such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in a HSA.

The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an Employer-sponsored Employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

An election to make a Contribution to your HSA can be increased, decreased or revoked at any time during the year on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election. See your Plan Administrator for more details.

3. Flexible Spending Accounts (FSAs)

There are some expenses you know you will have to pay for in the coming year; for instance, new eyeglasses, medical and dental care expenses not covered by the health plan, or perhaps care for a child or an incapacitated dependent adult while you are at work. Normally you would pay for expenses like these with after-tax income. And, because taxes reduce the value of your dollar, you would have to earn considerably more than $100 to pay for $100 of expenses.

If you are eligible to participate, the City of Luverne Flexible Benefits Plan allows you to contribute pretax income to create special accounts in order to reimburse yourself on a pretax basis for payment of certain medical and dependent care expenses. It is like getting a discount on these bills since you do not have to earn as much money to pay for them. The money you contribute to spending accounts by automatic payroll deduction is not subject to federal or Social Security taxes but, depending on your residence, may be subject to state and local income taxes.

How Health FSAs and Dependent Care Assistance Plan Spending Accounts Work

You may establish spending accounts for two separate categories of predictable expenses -medical care and dependent care. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pretax pay, deposited on a per pay period basis to the spending account you have elected. The minimum amount you may defer is $120.00 per Plan Year. The maximum pretax deferral for the Health FSA and for the Dependent Care Assistance Plan is outlined in Schedule D attached to this Summary. The Internal Revenue Code Section 125 states that these balances cannot be combined or used for purposes other than for which they were originally intended.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the Benefits Administrator of City of Luverne or the designated claims administration representative. Once the claims administrator receives the claims all claims will be processed for reimbursement on a monthly basis. Upon submission of a claim to your Health FSA, you will be reimbursed the full amount of your eligible expenses up to your elected Health FSA pretax deferral amount. However, you must have accumulated a sufficient credit balance in your Dependent Care Assistance Plan in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent months as more dollars are contributed from your pay to your Dependent Care Assistance Plan. If the Health FSA and/or Dependent Care Assistance Plan is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), you will be required to comply with substantiation procedures established by your Plan Administrator in accordance with IRS guidance. You must acquire and retain sufficient documentation to substantiate any expense paid with the debit card.

The Health FSA

Under this category are expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary," with substantiated claims and allowable as deductions under Code Section 213. Covered expenses do not include premiums paid for other health plan coverage, including plans maintained by the Employer of your Spouse or Dependents, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage. More detailed information about what is eligible and what is not eligible for reimbursement will be provided later in this Summary.

Reimbursable "Medical Care Expenses" will vary depending on which Health FSA coverage option you elect. If you have contributions to a Health Savings Account (HSA) during the year, you are only permitted to elect a Limited Health FSA, reimbursing dental, vision and preventive care and post deductible expenses, as outlined below. The following three options outline the definition of "Medical Care Expenses" as they relate to the General Purpose, Limited, and Employee Only Health FSA plans:

- *General-Purpose Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by you or your Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under Schedule E to this Summary, nor any expenses for which you or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, a Health Savings Account (HSA), or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.
- *Limited Purpose Health FSA Option* and *Post Deductible Health FSA Option.* **These are the only Health FSA options available to Employees funding a Health Savings Account (HSA).** The Limited Purpose FSA Option defines "Medical Care Expenses" as those expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however, that such expenses are limited to *vision care; dental care; and preventive care only*. The Post Deductible FSA Option defines "Medical Care Expenses" as those expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)—provided, however the expenses have been incurred after the minimum deductible for a qualified HSA insurance plan deductible has been satisfied. The minimum deductibles may change from year to year. Your Plan Administrator can advise you on what the minimum deductibles are. It is specifically the Employee's responsibility regarding Flexible Spending Account (FSA) reimbursements not to request anything that could violate the terms of the Employee's Health Savings Account (HSA).
- *Employee-Only Health FSA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by you (but not by your Dependent or Spouse) for medical care

as defined in Code § 213(d)—provided, however, that this term does not include expenses that are excluded under Schedule E to this Summary, nor any expenses for which you are reimbursed through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.

You must determine before the Plan Year starts which plan you elect and how much you will likely spend in out-of-pocket medical expenses. One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

The Dependent Care Assistance Plan Spending Account

Dependents are defined for this purpose as children up to age 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. If dependent care is required to enable you (or a Spouse or single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools and 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 nonrelative, as long as such a person is reporting payments as income, is also eligible.

Be aware that you may be able to take a federal tax credit for eligible expenses up to $3,000 (for one dependent) or $6,000 (for more than one dependent). The credit equals 35% of expenses, reduced by one percentage point (but not to drop below 20%) for each $2,000 (or fraction) by which your adjusted gross income exceeds $15,000. Any amounts deferred to a Dependent Care Spending Account will reduce dollar-for-dollar the maximum allowable expense under the tax credit. This can be confusing, you may want to consult with your tax advisor, or see IRS Publication No. 503 "Child and Dependent Care Expenses".

Spending Accounts - Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible spending accounts:

• Compensation redirection authorized for medical and dependent care expense reimbursement is in effect for the entire year unless you have a change in status such as those listed under "Election Changes" in this Summary Plan Description.

• You must use all of the funds in your spending accounts by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses. However, your Employer has amended the Health FSA Plan to permit up to $680.00 of unused funds from a prior Plan Year to carryover to the next Plan Year.

• You may request statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited. You may continue to submit claims up to three months after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given three months from their date of termination in which to submit expenses incurred prior to their termination for remaining Health FSA benefits. However a spend-down provision applies to the Dependent Care FSA that will allow you to use up your remaining benefits prior to the end of the Plan Year. You will be given three months from the end of the Plan Year to submit claims incurred for your Dependent Care Assistance Plan.

ELECTION CHANGES

You generally cannot change your election to participate in this Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but that will apply only for the upcoming Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule, known as “Change in Election Events.” Participants can change their elections under the Salary Reduction Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Changes in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Certain Judgments, Decrees, and Orders; Medicare and Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits - applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change

certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. A special HIPAA enrollment period of no more than 60 days is provided as of April 1, 2009 for Employees and their Dependents for loss of Medicaid or CHIP coverage; or upon becoming eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA and/or Dependent Care FSA enrollment. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence. You may change an election under the Salary Reduction Plan upon FMLA, non-FMLA, and USERRA leaves of absence.

2. Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment). "Spouse" means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code ("the Code");
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means your tax dependent under the Code;
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefits eligibility under a cafeteria plan (including this Salary Reduction Plan) or other Employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid; union to non-union; or full-time to part-time (or vice versa); incurring a reduction or increase in

hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular Employee benefit;

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance).
- a change in your, your Spouse's or your Dependent's place of residence.

3. Change in Status—Other Requirements. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility.

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age)*. But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute $100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of $700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of $700 for the year. In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (applies to Medical Insurance Plan and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased

Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Salary Reduction Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Salary Reduction Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

*IRS Notice 2010-38 states that the applicable Treasury Regulations have been amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

- *DCAP Benefits*. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

4. Special Enrollment Rights. *(Applies to Medical Insurance Benefits, but Not to Health FSA or DCAP Benefits.)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. When a special enrollment right applies to your Medical Insurance Benefits, you may change your election under the Salary Reduction Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. *(Applies to Medical Insurance Benefits and Health*

FSA Benefits, but Not to DCAP Benefits.) If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to Medical Insurance Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan, and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits and/or Health FSA Benefits, as applicable). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under Medicaid. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA and/or Dependent Care Assistance FSA enrollment.

7. Eligibility for Premium Assistance Subsidy. Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act if you become eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to Insurance Plans only, not to Health and/or Dependent Care Assistance FSA enrollment.

8. Change in Cost. *(Applies to Medical Insurance Benefits, and to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.)* If the cost charged to you for your Medical Insurance Benefits or DCAP benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage. (Note that, for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Medical Insurance Benefits; (b) an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and (c) coverage under another employer plan, such as the plan

of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.)

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits; you generally will have to notify the Plan Administrator of increases in the cost of DCAP benefits. The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

9. Change in Coverage. *(Applies to Medical Insurance Benefits and DCAP Benefits, but Not to Health FSA Benefits.)* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Medical Insurance Benefits or DCAP benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefits package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)
- *Addition or Significant Improvement of Salary Reduction Plan Option.* If the Salary Reduction Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under CHIP. The 60 day special enrollment period applies to Insurance Plans only, not to DCAP enrollment.
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.
  For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.
- *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

10. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. *No other benefits package option election changes can be made as a result of a change in your HSA Benefits election*. For example, generally you would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

11. Modifications Required by the Plan Administrator. The Plan Administrator may modify your election(s) downward during the Plan Year if you are a key Employee or highly compensated individual (as defined by the Code), if necessary to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Salary Reduction Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

MEDICAL CARE EXPENSES THAT MAY BE REIMBURSED FROM THE HEALTH FSA

For Health FSAs, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" now includes expenses for over-the-counter (OTC) drugs and medicines, as well as expenses for prescription drugs. Your Health FSA Account may reimburse reasonable quantities of over-the-counter (OTC) medical care items of the same kind purchased in a single calendar month; stockpiling is not permitted.

Schedule E of this Summary specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions on Schedule E will still not be reimbursable if such expenses do not meet the definition of "medical care" under Code § 213(d) and other requirements for reimbursement under the Health FSA.

For more information about what items are—and are not—Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in the Publication are not correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and

213(b)) and what is reimbursable as medical care under a Health FSA (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA.) And not all expenses that are reimbursable under a Health FSA are deductible. (For example, Health FSAs may reimburse OTC drugs that are prescribed by a physician if they qualify as medical care under Code § 213(d), but they are still not deductible under Code §§ 213(a) and 213(b).)

Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

COVERAGE FOR OVER-THE-COUNTER DRUGS AND OTHER PRODUCTS

The Coronavirus Aid, Relief and Economic Security (CARES) Act eliminated provisions that exclude the use of funds from HSAs and Health FSAs to purchase over-the-counter drugs without a prescription. The CARES Act also allows tax-free funds from these accounts to pay for menstrual care products. These changes apply to expenses that the Employee has incurred retroactive to January 1, 2020. This amendment will continue after December 31, 2020 for as long as allowed by law.

With the new law, eligible Employees are now able to purchase, or be reimbursed for, over-the-counter medications (examples: Tylenol, Motrin, cough suppressants; items that used to require a prescription) using your Health FSA without a prescription.

In addition, any menstrual hygiene products (tampons, sanitary napkins, liners, etc.) may also be purchased or reimbursed using Health FSA funds with this new law.

The law is retroactive to January 1, 2020, meaning any over-the-counter medications or menstrual products purchased since January 1, 2020 can be reimbursed from a Participant's Health FSA, if the expense has not already been reimbursed previously using a prescription benefit.

An eligible Employee may begin to use their Health FSA funds for over-the-counter medications and menstrual hygiene products as of January 1, 2020. This new law also has no expiration date, meaning you may continue to purchase these items with Health FSA funds for the entire Plan Year and beyond.

Employees with qualifying purchases on or after January 1, 2020 can submit a claim to be reimbursed from their Health FSA for over-the-counter medications not previously reimbursed with a

prescription benefit, as well as menstrual hygiene products. You will need to provide a copy of your receipt that shows proof of purchase date and item purchased (Health FSA).

FMLA LEAVES OF ABSENCE *(Applicable to groups of 50+ employees)*

If you go on a qualifying leave under the Federal Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis). If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Medical Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Medical Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Medical Insurance Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as

when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave. If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

NON-FMLA LEAVES OF ABSENCE

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes

as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

ABOUT TAXES

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through the Flexible Benefits Plan may offset any possible reduction in Social Security benefits.

FUTURE OF THE FLEXIBLE BENEFITS PLAN

The Flexible Benefits Plan is based on City of Luverne's understanding of the current provisions of the Internal Revenue Code. City of Luverne reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order will outline certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

MATERNITY AND NEWBORN COVERAGE

Since this Plan could offer maternity and newborn coverage under the Health FSA and one or more of the Health Insurance Plan(s), you are advised that under Federal law, this Plan and the insurers may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods.

REVISED DEFINITION OF "DEPENDENT" BY WFTRA

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

The following four criteria must be met to be a qualifying child:

- The individual has a specific family type relationship to the taxpayer
- The individual does not provide more than half of his or her own support
- The individual has the same place of residence as the taxpayer for more than half of the year
- The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition the following four criteria must be met to be a qualifying relative:

- The individual has a specific family type relationship to the taxpayer
- The individual is not a qualifying child of any other taxpayer
- The individual receives more than half of his or her support from the taxpayer
- The individual's annual gross income is less than the Section 151 limit (this criteria does <u>not</u> apply to health plans)

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

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

*NOTE: the Internal Revenue Service (the "IRS") Notice 2010-38 (the "Notice") provides important guidance regarding the tax treatment of Employer-provided health coverage to Employees' adult

children who have not attained age 27 as of the end of the Employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage for an Employee's adult children and the amounts paid by (or reimbursed to) the Employee for such coverage to be excluded from the Employee's gross income, in the same manner as coverage that is provided to an Employee's Spouse or Dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

YOUR PRIVACY RIGHTS UNDER HIPAA

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the Health FSA Plan from using or disclosing certain health information about you that is created or received by the Health FSA Plan without your written authorization. For additional information about your privacy rights, please either refer to the Plan's Privacy Notice or contact the Plan's Privacy Official: John Call or designee.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines **Protected Health Information (PHI)** as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment of the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The HIPAA definition of PHI applies to this plan and it restricts a Plan Administrator's use and disclosure of PHI. The Plan Administrator shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA, subject to the conditions of permitted disclosure and after obtaining written certification. The Plan may disclose PHI to the Plan Administrator, provide that the Plan Administrator uses or discloses the PHI for Plan administration purposes only. Plan Administration Purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as, claims processing, auditing, and monitoring.

The Plan may disclose to the Plan Administrator information on whether the individual is participating in the plan, or is enrolled in or has disenrolled from the Plan.

With respect to PHI disclosed by the Plan to the Plan Administrator, the Plan Administrator shall:

1. Not use or disclose the PHI other than is permitted or required by the Plan or by law.

2. Not use or disclose the PHI for employment-related actions and decisions.
3. Ensure that any agents, or subcontractors to whom PHI is provided, agrees to the same privacy restrictions and conditions that apply to the Employer and the Plan Administrator.
4. Report to The Plan any use or disclosure of PHI that is any violation of the HIPAA Privacy Rule.
5. Make available PHI to comply with the HIPAA right to access in accordance with the law.
6. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
7. Return or destroy all PHI received from the Plan that the Employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
8. Satisfy the requirement of adequate separation between the Plan and the Employer.

The Employer shall allow only the PHI Officer and other designated persons, access to PHI. These specified Employees, or classes of Employees, shall only have access to and use PHI to the extent necessary to perform the Flexible Benefits Plan administration functions that the Plan Administrator performs for the Plan. Any of these specified Employees who do not comply with the provisions of this Section, shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's Employee discipline and termination procedures.

COBRA CONTINUATION COVERAGE *(Generally applicable to groups of 20+ employees)*

If you terminate employment, under Federal law, you, your Spouse, and/or your covered Dependents lose coverage under this Plan. You, your Spouse, and/or your covered Dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more Employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or

within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an Employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" Employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

(a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.

(b) Your Spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a Spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Administrator of

your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

"*Medicare*" means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

Note: COBRA provides limited continuation coverage under the Health FSA and does not apply to Dependent Care Assistance Plans. A spend-down provision applies to balances remaining in these accounts through the end of the Plan Year, provided a claim is submitted within 90 days of the end of the Plan Year.

COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The information furnished herein constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished. Note: Dependent care assistance plans and health savings accounts are not covered under the Employee Retirement Income Security Act (ERISA).

ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all Employer-sponsored group benefit programs conform to standards set by Congress. An Employee who is a Participant in the Health FSA is entitled to certain rights and protections under ERISA (Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA), however, for administrative convenience, this DCAP uses similar procedures for administration of DCAP claims), which provides that all Participants will be entitled to: (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, such as copies of the latest annual reports (Form 5500), if any, and Plan descriptions; (2) obtain copies, upon written request to the Plan Administrator copies of all Plan documents and other Plan information governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report. Plan records are kept on a Plan Year basis.

In addition to creating rights for plan Participants, ERISA imposes duties upon those responsible

for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA, there are steps the Employee covered under the Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Employee covered under the Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant is successful, the court may order the person sued to pay these costs and fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, 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, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 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.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. Your specific rights to benefits under the plan are governed solely, and in every respect, by the City of Luverne Health FSA Plan Document, a copy of which is available from Jill Wolf upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and City of Luverne or a Participating Employer. City of Luverne's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Plan Definition and Funding

This is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code. It includes a Section 105 Health Flexible Spending Account, classified by the Department of Labor as a "welfare" plan, and a Section 129 Dependent Care Flexible Spending Account. The Plan is funded by Employee contributions.

General Information

- Name: City of Luverne Flexible Benefits Plan (501).
- Plan Number: 501
- Effective Date: January 1, 1991, amended January 1, 2026
- Plan Year: January 1 to December 31

Type of Plans

Section 125 Premium Only Plan with HSA module
Health Flexible Spending Account
Dependent Care Assistance Plan Flexible Spending Account

Participants

The plan provides benefits for all Employees of City of Luverne and any Participating Employers who meet the eligibility requirements described herein.

Employer/Plan Sponsor Information

City of Luverne, 305 E. Luverne St.; P.O. Box 659, Luverne, MN 56156
Phone: 507-449-2388

Employer Identification Number (EIN): 41-6005329

Plan Administrator Information

City of Luverne, 305 E. Luverne St.; P.O. Box 659, Luverne, MN 56156

Phone: 507-449-2388

Named Fiduciary

City of Luverne, 305 E. Luverne St.; P.O. Box 659, Luverne, MN 56156

Phone: 507-449-2388

Agent for Service of Legal Process

City of Luverne, 305 E. Luverne St.; P.O. Box 659, Luverne, MN 56156

Phone: 507-449-2388

CITY OF LUVERNE
FLEXIBLE BENEFITS PLAN
QUESTIONS AND ANSWERS

INTRODUCTION

As part of our efforts to keep your medical benefit costs as affordable as possible, City of Luverne (referred to in these questions and answers as the "Company") is pleased to sponsor the City of Luverne Flexible Benefits Plan (the "Plan").

The Plan provides each Eligible Employee with the opportunity to set aside part of his or her pay on a *pre-tax* basis to:

(1) pay for his or her share of health insurance premiums under the health care program(s) sponsored by the Company;

(2) make Health Savings Account (HSA) contributions pretax to the Employee's HSA trustee/custodian;

(3) provide for reimbursement of unreimbursed medical and dental expenses on a *tax-free* basis; and,

(4) provide for reimbursement of eligible dependent care expenses you may incur as a result of work.

The Plan helps you because the benefits you elect are nontaxable. In addition, you save Social Security and income taxes on the amount of your salary reduction used to pay for these expenses.

Following are commonly asked questions and answers describing the basic features of the Plan and how it operates. Please review these questions and answers carefully, and do not hesitate to ask questions. This is *your* benefit, and it is important that you understand how it works and how it can help you. However, you should note that the questions and answers address only the key parts of the Plan. Consult the Plan documents or summary plan description for more details. Or, contact Jill Wolf at the Company.

QUESTIONS & ANSWERS

1. What is the purpose of the Plan?

The purpose of the Plan is to permit Eligible Employees to elect to defer part of their pay on a pre-tax basis to defray their health insurance expenses, HSA contributions, unreimbursed medical expenses and dependent care expenses.

2. What benefits are offered through the Plan?

Four kinds of benefits are offered under the Plan: a "Premium Only Plan", a "Health Savings Account Contribution Benefit", a "Health FSA Benefit", and a "Dependent Care Assistance Plan (DCAP) Spending Account". These benefits are explained in more detail below.

3. Who may participate in the Plan?

If you regularly work 40 or more hours per week with the Company or with any affiliated company that has adopted the Plan, you are eligible to participate in the Plan after the completion of one day of active employment with the Company. Only C Corporation Owners may participate in the Plan. Sole Proprietors, more than 2% owners of S Corporations and family members, Partners, and LLC owners are specifically excluded from participating by IRS Code.

4. What is the Premium Only Plan Benefit and HSA Benefit?

The Premium Only Plan allows you to pay your share of the health insurance premiums and other ancillary benefits with *pre-tax* dollars. If you do not elect to receive pre-tax benefits under the Premium Only Plan, you still will have to pay your share of the health insurance premiums under the Company's health care program(s), but on an *after-tax* basis. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

An HSA Benefit permits Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Employee's HSA trustee/custodian. For purposes of this Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under this Plan.

5. How does the Health FSA Benefit help me?

It is likely that you will have some medical expenses that you will have to pay for in the coming year. For example, you or your family may have medical expenses that are subject to deductible or co-payment limits under the Company's health plan. Or you may incur expenses that are not reimbursed at all. Normally, you would pay for these expenses with after-tax income. And, because taxes reduce the value of a dollar, you would have to earn considerably more than $100 to pay for $100 of expenses.

The Health FSA Benefit under the Plan permits Eligible Employees to contribute *pre-tax* income to a Health FSA on your behalf. The Health FSA will reimburse you on a pre-tax basis for your unreimbursed medical expenses. It's like getting a discount on these bills so you don't have to earn as much to pay for them.

6. How does the Health FSA Benefit work?

Once you have determined your annual predictable medical expenses for the plan year (or part thereof, if you first become eligible to participate in the middle of a plan year), you may elect to defer a portion of your salary into a Health FSA maintained on your behalf. You should take into account your health insurance deductibles and copayments, as well as uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary" as covered under Section 213 of the IRS code. Do not take into account premiums paid for health insurance coverage provided by the Company (since this is covered under the Premium Only Plan). Also, do not take into account other health insurance coverage, such as that of your Spouse, or expenses for cosmetic surgery.

7. How much may I contribute to my Health FSA?

The maximum amount you may elect to defer into a Health FSA for a year is outlined in Schedule D attached to this Summary.

8. What is an "eligible expense" under the Health FSA?

An "eligible expense" means any items for which you can claim a medical expense covered under the Code Section 213 (with some limitations, see the Summary Plan Description for complete details) of the IRS. It is an expense for which you have not otherwise been reimbursed from insurance or some other source. *Employees who have contributions to their Health Savings Account (HSA) during the year, must use their Health Flexible Spending Account (FSA) as a Limited Purpose FSA or a Post Deductible FSA only.*

Please review the list of eligible medical expenses provided in your City of Luverne Summary Plan Description for assistance in determining what is an "eligible expense".

9. How do I receive medical expense reimbursements under the Plan?

To receive reimbursement, you must complete a claim form and attach any other information as the Plan Administrator may require. The Plan Administrator will instruct you as to how to file the form. When the claim is approved, you will be reimbursed the full amount of your eligible expenses, up to your elected Health FSA limit.

10. What happens to the money in my Spending Account(s) should I terminate?

You may submit claims on expenses incurred before the date of your termination, up until three months after you leave. If applicable, you may elect continuation coverage through COBRA and you may continue to use your Health FSA. Regarding the Dependent Care Assistance Plan you may spend down the unused portion of your account prior to the end of the Plan Year. Funds left

unclaimed at year-end will be forfeited.

11. How long do I have after the Plan Year ends to submit my claims?

You will have three months after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment. A terminated Employee has three months from their date of termination to submit claims incurred in that Plan Year.

12. What else should I know about the Health FSA Benefit?

The IRS imposes certain restrictions on Health FSAs and DCAPs, including the following:

- Authorized salary reductions into your Health FSA and DCAP may not be changed for the rest of the year unless you terminate employment or have a change in status. Changes in status are discussed in detail in the Summary Plan Description.
- Generally, you will forfeit all unused funds in your Health FSA at the end of the year. This is the "use it or lose it" rule. Unused balances may not be carried over to the next year or converted to cash. For this reason, you should estimate your anticipated medical expenses for the year *conservatively.* Notwithstanding the above, your Employer has amended the Plan to permit a carryover of up to $680.00 of a Participant's unused FSA account balance to the following Plan Year.
- You may request periodic statements to remind you how much money is left in your Health FSA and DCAP. As indicated above, these amounts must be used by the end of the year or they will be lost, unless your Employer has adopted a Grace Period, allowing additional time to incur expenses that are reimbursed from the prior Plan Year unused account balances. Claims may be submitted up to three months after the end of the plan year in which the expenses were incurred. If you terminate employment, you may submit claims up to three months after you terminate employment.

12.1 Will I be able to file claims for over-the-counter drugs from the Health FSA?

Effective January 1, 2020 the Coronavirus Aid, Relief and Economic Security (CARES) Act law allows eligible Employees to purchase, or be reimbursed for, over-the-counter medications (examples: Tylenol, Motrin, cough suppressants; items that used to require a prescription) using your Health FSA without a prescription. In addition, any menstrual hygiene products (tampons, sanitary napkins, liners, etc.) may also be purchased or reimbursed using Health FSA funds with this new law.

The law is retroactive to January 1, 2020, meaning any over-the-counter medications or menstrual products purchased since January 1, 2020 can be reimbursed from a Participant's Health FSA, if the expense has not already been reimbursed previously using a prescription benefit.

13. What is the maximum amount of salary I can deposit per pay period to a Dependent Care Assistance Plan (DCAP) Spending Account?

The maximum you may deposit to a DCAP Account is $625.00 monthly, or $7,500 per year. If you are married and file separately the maximum amount is $312.50 per month, or $3,750 per year.

14. How often will claims be paid under the DCAP?

Claims will be paid each month after you submit them, up to the balance of your account. Portions of your approved but unreimbursed expenses will be paid monthly as your account rebuilds.

15. Who is an "Eligible Dependent" for whom I can claim a reimbursement under the Dependent Care Spending Account?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13 whom you could claim as a dependent on your federal income tax return; any other dependent who is mentally or physically unable to care for himself or herself; or your Spouse, if he or she is physically or mentally incapacitated. See the section titled '**Revised Definition of "Dependent" by WFTRA'** in this Summary for more information on the definition of Dependents.

To have your claims processed as soon as possible, please read the Claims Instructions you have been furnished. Please note that it is not necessary that you have actually paid the amount due for an Eligible Dependent Care Expense - only that you have incurred the expense and that it is not being paid by or being reimbursed from any other source.

16. Will I be taxed on the Dependent Care Assistance Plan benefits I receive?

You will not normally be taxed on your Dependent Care benefits, up to your DCAP Account deferral amount. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

17. If I participate in the DCAP will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan. However, the balance of your dependent care expenses not eligible for reimbursement under this Plan, if any, may be eligible for the dependent care credit.

18. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, eligible work-related dependent care expenses as a credit against your federal income tax liability under the

Internal Revenue Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one dependent, or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit of $1,050 for one dependent or $2,100 for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents). The maximum 35% rate must be reduced by 1% (but not below 20%), for each $2,000 (or any fraction of $2,000), of your adjusted gross income over $15,000. If this is too confusing, consult with your tax advisor, or see IRS Publication No. 503 "Child and Dependent Care Expenses".

19. Are my Plan benefits taxable?

Under current law, the benefits you receive under the Plan are not currently taxable to you, nor are the benefits subject to federal income tax withholding and Social Security (FICA) withholding taxes.

20. Will the Health FSA claims I submit to my plan administrator be kept private?

Yes, HIPAA Rules require that Protected Health Information (PHI) given to the plan administrator be kept completely confidential. See the Summary Plan Description for the complete Privacy Statement regarding PHI.

21. How does the Plan save me money?

The following example illustrates how the Plan saves you money. Assume that your monthly share of the health insurance premium is $400 per month, your monthly income is $4,000, and you are in the 28-percent federal income tax bracket and the 7.5-percent state tax bracket. Assume also that you expect to have $2,400 in uninsured medical expenses during the year. If you pay your health insurance premiums using the Premium Only Plan and your uninsured medical expenses using the Health FSA Benefit, you will save $259 per month, or $3,108 per year. These amounts are computed as follows:

Your Salary	**Pre-Tax Medical Plan $4,000**	**No Pre-Tax Medical Plan $4,000**
LESS YOUR:		
Health Insurance Premium	(400)	0
Uninsured Medical Expenses	(200)	0
Taxable Income	**3,400**	**4,000**
LESS YOUR:		
Federal Income Tax at 28%	(952)	(1,120)
State Income Tax at 7.5%	(255)	(300)

Social Security (FICA) at 7.65%	(260)	(306)
Health Insurance Premium	0	(400)
Uninsured Medical Expenses	0	(200)
Net Take Home Pay	1,933	1,674
Monthly Tax Savings	**259**	-----
Annual Tax Savings With This Plan	**3,108**	-----

22. When and how do I elect the Plan benefits?

You will be provided a form when you first become eligible to participate. This form will notify you of your eligibility for participation in the Plan, upon which you may elect the Premium Only Plan, Health Savings Account contributions, Health FSA Benefit and/or the DCAP. If you elect the Premium Only Plan, the health insurance premiums you are already making will be converted to a pre-tax basis.

In future years, you will be furnished a new form by the first day of the annual enrollment period and be given the opportunity to confirm or change your existing choices for the coming calendar year.

23. The Plan sounds too good to be true. Are there any reasons why I shouldn't participate?

As discussed above, the salary you elect to use to pay for Plan benefits is free from income and FICA taxes. This is a valuable benefit. However, because amounts deferred under the Plan are not counted as wages when determining your Social Security benefit, it is possible that there may be a reduction in your Social Security benefits. If your salary is above the Social Security Taxable Wage Base you probably will not be affected. If your salary is below the Social Security Taxable Wage Base, your Social Security benefits might be reduced. You should consult your own financial or tax advisor to determine the effects of electing to participate in the Plan. If you are using the Plan for reimbursement of insurance premium, it is specifically your responsibility not to request anything that could violate the terms of your insurance policy.

24. Can I change my election during the Plan Year?

Generally, you may not change or vary your elections during the Plan Year. However, you may change your elections during the annual enrollment period for the coming Plan Year. The Plan Administrator will advise you when you may elect to change your elections for the upcoming plan year.

There is an important exception to this general rule: You may change or revoke your election at any time during the Plan Year if you have a qualifying change in status (which generally includes a

change in your legal marital status or change in the number of dependents). See the qualifying changes in status listed under "**Election Changes**" in this Summary.

25. Who holds the funds I have set aside under the Plan?

The insurance companies providing the benefits under the Plan will receive all amounts withheld from your paycheck for payment of premiums. The HSA financial institution will receive all amounts designated as Health Savings Account contributions. Amounts contributed under the Health FSA and DCAP benefits will be retained by the Company but earmarked to pay for Health FSA and DCAP Benefits. Separate bookkeeping entries will be maintained to keep track of your Health FSA and DCAP Benefits.

26. When will my participation in the Plan cease?

If you elect to participate in the Plan, your participation will continue until you separate from service with the Company or elect to stop making contributions under the Plan. Also, with respect to this Plan, if your employment status changes so that you regularly work less than 40 hours per week, your participation in the Plan will cease. However, you may be eligible for continuation coverage under this Plan.

27. What is continuation coverage?

If you, your Spouse, and/or your covered Dependents lose coverage under this Plan, you may be entitled to COBRA continuation of health care coverage, including the Health FSA. Generally, if the Employer has employed twenty (20) or more Employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a specific period of time. The Administrator will inform you of these rights if you lose coverage and you are entitled to continuation coverage.

The Dependent Care Assistance Plan provides a "spend down" period entitling you to claim reimbursement for any qualifying Dependent Care Expenses incurred after termination and before the end of the current Plan Year. Qualifying Dependent Care Assistance expense claims must be filed within 90 days of the end of the Plan Year.

28. Will I have any administrative costs under the Plan?

No. The Company will pay the entire cost of administering the Plan.

29. How long will the Plan remain in effect?

The Company has the right to modify or terminate the program at any time, or to elect not to continue sponsorship of the Plan.

30. What happens if my claim for benefits is denied?

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the Health FSA are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Plan Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Health FSA's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Plan Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission.

If you do not file your appeal within this 180-day period, you lose your right to appeal.

Your appeal will be heard and decided by the Committee.

F. How will my appeal be reviewed?

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Committee. The Health FSA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Health FSA who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

G. When will I be notified of the decision on my appeal?

The Committee must notify you of the decision on your appeal within 60 days after receipt of your request for review.

H. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Committee will include the

following information:

- The specific reason for the denial upon review;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring a civil action under ERISA § 502(a).

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

31. Can I request an external review if my appeal is denied?

If the Health FSA is an excepted benefit, it is not subject to external review requirements. To be an excepted benefit, the Health FSA must satisfy two conditions:

1. Maximum Benefit Condition. The maximum benefit payable under the Health FSA to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the Health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the Health FSA for the year, plus $500).
2. Availability Condition. Other nonexcepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment.

If the Health FSA is not an excepted benefit, it is subject to external review requirements. If the denial of your claim is not related to your (or your beneficiary's) failure to meet the requirements for eligibility under the terms of your Employer's HRA, you may be eligible to request an external review. View current procedures and timeline relevant to the external review request at http://www.dol.gov/ebsa or call the Employee Benefits Security Administration, 866-444 EBSA (3272).

CITY OF LUVERNE

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
HSA High Deductible Group Health Insurance
HSA Tax-Free Savings Account
Group Term Life Insurance (Employee Only)
Vision Insurance

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment and in Schedule B. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

<u>CITY OF LUVERNE</u>

Schedule B

FORMULA FOR EMPLOYEE CONTRIBUTIONS UNDER THE PLAN

The following description of the Employee Contribution per Participant may be expressed as a percentage of monthly cost, or as a flat monthly dollar amount. If the formula for Employee contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.*

Name of Benefit Plans To Be Offered		Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%
	ER	$/%	$/%	$/%	$/%
	EE	$/%	$/%	$/%	$/%

*An asterisk in the premium column means there are multiple rates based on age, sex, or other demographics. Please refer to specific insurance carrier premium rate sheets for individual maximum elective contribution.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, co-payment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

ER = Employer Contribution
EE = Employee Contribution

CITY OF LUVERNE

Schedule C

PARTICIPATING AFFILIATED EMPLOYERS

(Companies under common ownership)

The following organizations and entities shall be Participating Employers under the Plan:

Name of Participating Employer

None

CITY OF LUVERNE

SCHEDULE D

HEALTH FSA AND DEPENDENT CARE ASSISTANCE PLAN

EMPLOYEE CONTRIBUTION LIMITATIONS

	Minimum*	Maximum*
HEALTH FLEXIBLE SPENDING ACCOUNT	**$10.00**	**$283.33**
DEPENDENT CARE ASSISTANCE PLAN	**$10.00**	**$625.00**

*Monthly, based on a 12 month Plan Year; Health FSA annual maximum is $3,400.00
Dependent Care FSA annual maximum is $7,500.00

A list of qualifying Health Flexible Spending Account expenses is available at:
www.coredocuments.com/expenses.php.

CITY OF LUVERNE

SCHEDULE E

HEALTH FSA EXCLUSIONS
MEDICAL EXPENSES NOT REIMBURSEABLE

The City of Luverne Health FSA Plan document contains the general rules governing what expenses are reimbursable. This Schedule E, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the Health FSA—that is, expenses that *are not reimbursable*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under the regulations governing Health FSAs.

This Schedule E does not apply to HSAs. As described in the Plan, terms and conditions of coverage and benefits under the HSA (including eligible medical expenses and exclusions) will be provided by and are set forth in the HSA, not this Plan.

Exclusions: *The following expenses are not reimbursable from the Health FSA*, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs:

• Dual purpose products, items for general well-being, or items not typically medically necessary (such as Acupuncture, Supplements, Vitamins, Massage Therapy, Dermatology Products, and Weight Loss Programs) are excluded from reimbursement unless accompanied by a letter of medical necessity. The letter of medical necessity must be from a Physician and must include a diagnosis, duration of treatment, and description of treatment plan. • Health insurance premiums for any other plan (including a plan sponsored by the Employer). • Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. • Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework). • Long-term care services.	• Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods. • Social activities, such as dance lessons (even if recommended by a physician for general health improvement). • Bottled water. • Cosmetics, toiletries, toothpaste, etc. • Uniforms or special clothing, such as maternity clothing. • Automobile insurance premiums. • Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician. • Any item that does not constitute "medical care" as defined under Code § 213(d). • Any item that is not reimbursable under Code § 213(d) due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations. • The salary expense of a nurse to care for a healthy newborn at home. • Custodial care. • Funeral and burial expenses.

City of Luverne
Premium Election Form

- ❑ Correction
- ❑ Change of personal information
- ❑ Change of Family Status
- ❑ Transfer
  Effective Date_____
- ❑ Termination
- ❑ Waive Participation _____ (initial)

Personal Information

Last Name	First Name	Middle Initial	Social Security Number

Home Address	Street	City	State	Zip

Date of Birth: / / Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married Date of Hire: / /

Benefit Elections (Circle coverage elected and enter appropriate amount on total cost per month line.)

(Employee Cost Per Month*)

Name of Benefit Plans To Be Offered	**Employee Only**	**Employee & Child(ren)**	**Employee & Spouse**	**Employee & Family**
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____

* Amount after employer contribution is deducted **Total Cost Per Month $_____**

Salary Reduction Agreement

I have read and understand the explanation I have received regarding my options under the City of Luverne Premium Only Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents; termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility; a change in residence for me, my spouse or children; or my dependent either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances; or a change in my or my spouse's employment status.

It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy. I understand that subsidized insurance premiums can only be deducted on a post-tax basis.

I hereby apply for the options listed above. If necessary, I authorize City of Luverne to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from January 1 until December 31, unless my family status changes.

_____ _____
Employee Signature Date

_____ _____
Company Representative Date

CITY OF LUVERNE
HEALTH SAVINGS ACCOUNT

ENROLLMENT ELECTION FORM

Applicant Name: _____

Email Address: _____

Contribution Information:

Employee Contributions:

- Annual Contributions: $_____
- Pay Period/Month Contribution: $_____
- Number of pay periods annually: _____

Total Annual Contributions: $_____
Total Pay period Contribution: $_____

Employer Contributions:

- Annual Contributions: $_____
- Pay Period/Month Contribution: $_____
- Number of pay periods annually: _____

Total Annual Contributions: $_____
Total Pay period Contribution: $_____

Signatures: (Please read before signing)

I understand the eligibility requirements for the HSA which I am establishing, and I state that I do qualify to make deposits. I understand the terms and conditions which apply to this HSA, and I agree to be bound by those conditions.

I assume complete responsibility for: (1) Determining that I am eligible for the HSA each year I make contributions, (2) ensuring that all contributions I make are within the limits set forth by the tax laws, and (3) ensuring that all contributions from the HSA are for qualified medical expenses as defined by Section 213(d) of the tax code.

I authorize my employer to deduct my contributions each pay period and send them to:_____

_____for placement in my Health Savings Account.

I understand that I may close my HSA account with prior written notification. All remaining funds will be forwarded to me within 30 days of the written notification being received. I understand that any monies not rolled to a new HSA Plan, or spent on Qualified Medical Expenses will be subject to additional taxes and penalties through the IRS.

_____

HSA Holder Signature Date

_____

Employer Signature Date

Employer must sign if he/she is contributing to the employee HSA account

Administrator
City of Luverne
305 E. Luverne St.; P.O. Box 659
Luverne, MN 56156

CITY OF LUVERNE
HEALTH FSA ELECTION FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ Effective Date_____

Name_____ Waive Participation_____ (initial)
(Last) (First) (MI)

Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ___ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____
I prefer to be contacted regarding my FSA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

DEPENDENT INFORMATION (Must List ALL eligible Dependents Affected by Enrollment)

Last Name	First Name	Relationship (Self/Spouse/Child)	M/F	SS#	Date of Birth
Employee		*Self*			
Dependent					
Dependent					
Dependent					
Dependent					

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

HEALTH FLEXIBLE SPENDING ACCOUNT - Employer Contribution ☐ NO ☐ YES $_____Annual Benefit

PAYROLL SCHEDULE ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

EMPLOYEE ELECTION $_____/Per Pay Period $_____/Annually (from your Effective Date until December 31)

TYPE OF PLAN: ☐GENERAL PURPOSE ☐LIMITED PURPOSE / POST DEDUCTIBLE ☐EMPLOYEE ONLY

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs. Changes must be submitted within 30 days of the qualifying event.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits from my Insurance Provider, itemized bill, etc.) for out-of-pocket Medical, Dental, Vision expenses before I can be reimbursed.

I understand that the plan provisions will require that all Health FSA participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options, if applicable (see your Summary Plan Description regarding COBRA qualifications). If the continuation for the Health FSA is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

I hereby elect to participate in Flexible Spending Account as indicated on this form. I authorize City of Luverne to make pretax deductions from my salary on the payroll schedule I have elected above. I understand that to stop such deduction, I must notify City of Luverne Benefits office in writing with my request, and revoke this authorization.

Notwithstanding any amendments to the Plan to permit a 2.5 month grace period or the carryover of up to $500 of unused account balances, any unused dollars remaining in my Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that I participated in the Plan in order to be eligible for reimbursement.

Employee's Signature _____ Date: _____

CITY OF LUVERNE
HEALTH FSA
REIMBURSEMENT CLAIM FORM

PERSONAL DATA (Please Print)

Name	SS# (Last four digits only) X X X – X X –
Home Address	Address Change: ☐Yes ☐No
City	State / Zip
Phone: Work ( ) Home/Cell ( )	Email: I prefer to be contacted by Email, Wk Ph, Hm Ph, Mail (***circle one***)

You must provide a receipt showing the date of service, amount of service, description of service, name of service provider, and name of patient or other evidence the expense was incurred (such as an EOB from your Insurance Provider). If this form is incomplete your claim could be denied. Print or type the information requested, then sign and date the form.

	Name of Medical Provider (Doctor, Pharmacy, etc.)	Date Medical Care Provided*	Patient Name	Relationship (Self, Spouse, Child)	Amount that is your responsibility	General Medical Expense Description.
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
9					$	
10					$	
		Total Medical Amount Requested →				$

Please arrange documentation in order listed above.

***Claims for future services will not be accepted**

I request payment from my **Health Flexible Spending Account** (FSA) as indicated above for the expenses listed. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while I was enrolled in the employer's FSA with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify that these expenses will not be claimed as an income tax deduction. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I authorize my **FSA** to reimburse me by the amount requested.

☐ **I am funding an HSA for this Plan Year** ☐ **I am NOT funding an HSA for this Plan Year**

Employee Signature_____ Date_____

SUBMIT YOUR COMPLETED CLAIM FORM TO:

City of Luverne
305 E. Luverne St.; P.O. Box 659
Luverne, MN 56156

CITY OF LUVERNE
DEPENDENT CARE ASSISTANCE PLAN
ELECTION FORM

(Please Print)

1. PERSONAL DATA PLAN YEAR_____ Effective Date of Enrollment/Change _____

Name_____ Waive Participation_____ (initial)
(Last) (First) (MI)

Marital Status:_____ Date of Hire_____ Soc. Sec. _____ - ___ -_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

Email _____ Work Phone_____Home/Cell Phone _____

I prefer to be contacted regarding my FSA Account via Email ____, Wk Ph____, Hm/Cell Ph_____, 1st Class Mail_____

DEPENDENT INFORMATION (Must List ALL Dependents Affected by Enrollment)

Last Name	First Name	Relationship	M/F	SS#	Date of Birth
Dependent					
Dependent					
Dependent					
Dependent					

2. FLEXIBLE SPENDING ACCOUNT CONTRIBUTIONS

DEPENDENT CARE ASSISTANCE PLAN ☐YES ☐ NO $_____/Per Pay Period $_____/Annually

PAYROLL SCHEDULE ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

DEPENDENT CARE FSA CONTRIBUTIONS TO BEGIN ON _____ (*First Pay Date after Effective Date*)

3. AUTHORIZATION AND ACKNOWLEDGEMENT

I understand that I cannot revoke or change this election during the year unless there is a qualifying "Status Change". The requested election change must be consistent and in line with the qualifying event. I may then revoke my prior election and sign a new Agreement if such a change occurs.

I understand that I must submit a claim and appropriate documentation for out-of-pocket Dependent Care Expenses before I can be reimbursed.

I understand that the plan provisions will require that all DCAP participants who have a positive balance (taking into account all claims submitted prior to termination) at the time of terminating employment will be provided with information regarding their COBRA options, if applicable (see your Summary Plan Description regarding COBRA qualifications). If the continuation for the DCAP is not elected, I realize that I will not be reimbursed for any expenses incurred after the date employment terminates.

I hereby elect to participate in the Flexible Spending Account as indicated on this form. I authorize City of Luverne to make pretax deductions from my salary on the payroll schedule I have elected above. I understand that to stop such deduction, I must notify City of Luverne Benefits office in writing with my request, and revoke this authorization.

Any unused dollars remaining in your DCAP Flexible Spending Account at the end of the year will be forfeited. Expenses/claims must be incurred during the time that you participated in the plan in order to be eligible for reimbursement**.**

SIGNATURE_____ DATE_____

CITY OF LUVERNE
DEPENDENT CARE ASSISTANCE PLAN
REIMBURSEMENT CLAIM FORM

(Please Print)

1. PERSONAL DATA **PLAN YEAR**_____ **SS#** (Last four digits only) XXX–XX–_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

2. DEPENDENT CARE EXPENSES

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period
		From	To*		
		Total Dependent Care Amount Requested →			

I provided the dependent care as stated above.

x_____ _____ _____
Care Provider's **original** signature Date SSN/Tax ID#

3. TERMS AND CONDITIONS

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's DCAP with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Employee's Signature Date

SUBMIT YOUR COMPLETED CLAIM FORM TO:

City of Luverne
305 E. Luverne St.; P.O. Box 659
Luverne, MN 56156

Notice: All employees participating in a Section 129 Dependent Care Assistance Plan are required to file Form 2441 with the IRS by April 15 of the year following your participation in this plan.

CITY OF LUVERNE
FLEXIBLE BENEFITS PLAN
CHANGE AND REVOCATION FORM

(Please Print)

PERSONAL DATA **PLAN YEAR**_____ Soc. Sec. #_____

Name_____ Home Phone #_____

Address_____
(Street) (Apt. #) (City) (State) (Zip)

CHANGE OR REVOCATION OF SALARY REDUCTION AGREEMENT

Please indicate the change in your Salary Reduction Agreement in the area below. If there is a status change event, change in cost/coverage or other-type change (judgment decrees, etc.) that is permitted under the Internal Revenue Code and Regulations, and which justifies a change in your Salary Reduction Agreement, you may change or revoke your Salary Reduction Agreement. However, once you make the change indicated on this form, you may not reinstate or revise your Salary Reduction Agreement as of a date before the first day of the next Plan Year unless there is another status change event, change in cost/coverage or other-type allowable change (judgments, decrees, etc.). Please Note: In most circumstances, you must submit the Change and Revocation Form within **30 days** of qualifying event.

Premium-type Benefits

If you are changing from one level of coverage, from single to family coverage for example, mark "Revoke" for your current coverage (e.g. single) and mark "New Enrollment" for the new coverage (e.g. family).

If you are ending participation in the Plan, mark "Revoke".

Current Election	Revoke/ Suspend	New Enrollment	Effective Date
**** Health Insurance ****			
[ ] Employee Only	[ ]	[ ]	___/___/___
[ ] Employee Plus Dependents	[ ]	[ ]	___/___/___
**** Dental ****			
[ ] Employee Only	[ ]	[ ]	___/___/___
[ ] Employee Plus Dependents	[ ]	[ ]	___/___/___
** _____ **			
[ ] Employee Only	[ ]	[ ]	___/___/___
[ ] Employee Plus Dependents	[ ]	[ ]	___/___/___

Flexible Spending Arrangements

If you are reducing or increasing your salary reductions, please indicate the new amount PER PAY PERIOD under "New Enrollment". If you are ending participation in the Plan, mark "Revoke".

Current Election	Revoke/ Suspend	New Enrollment Salary Reduction	Effective Date
[ ] Dependent Care FSA	[ ]	_____.__	___/___/___
[ ] Medical Expense FSA	[ ]	_____.__	___/___/___

Reason for Election Change – please mark [X] the appropriate election change event(s) that justifies the change(s) or revocation(s) on this form and enter the date(s) of the event(s)

1. Status Change Events

a. Change in Marital Status

[ ] Marriage on ___/___/___
[ ] Divorce on ___/___/___
[ ] Annulment on ___/___/___
[ ] Legal Separation on ___/___/___
[ ] Death of Spouse on ___/___/___

b. Change in Number of Tax Dependents

[ ] Birth on ___/___/___
[ ] Adoption on ___/___/___
[ ] Other – Gain Tax Dependent on ___/___/___
[ ] Death of Dependent on ___/___/___
[ ] Death of Spouse on ___/___/___

Reason for Election Change *(continued)*

c. Change in Employment Status With Gain or Loss of Eligibility -

Change relates to: *[ ] Employee* *[ ] Spouse or Dependent*

[ ] Termination of Employment on ___/___/___ [ ] Full-time to Part-time on ___/___/___

[ ] Commencement of Employment on ___/___/___ [ ] Part-time to Full-time on ___/___/___

[ ] Commencement of Unpaid Leave on ___/___/___ [ ] Return from Unpaid Leave on ___/___/___

[ ] Other (hourly to salary, union to non union, change in worksite, etc.) on ___/___/___

Provide Details: _____

_____

d. Change in Dependent Eligibility Under an Employer's Plan

[ ] Lost Eligibility (age, student status, attainment of age 13 for Dependent Care FSA, COBRA event, etc.) on ___/___/___

[ ] Gain Eligibility (e.g., age, student status, etc.) on ___/___/___

e. Change of Residence Affecting Eligibility – Date of change ___/___/___

Change relates to: *[ ] Employee* *[ ] Spouse or Dependent*

f. Commencement or Termination of Adoption Proceedings Date of change ___/___/___

(applies to Dependent Care FSAs only)

2. Special Enrollment Rights – HIPAA *(applies to Premium benefits only)*

[ ] Loss of other group health plan coverage on ___/___/___

[ ] Acquired new spouse or dependent (marriage, birth, etc.) on ___/___/___

[ ] Eligible for Premium Assistance Subsidy on ___/___/___

3. Certain Judgments, Decrees and Orders *(applies to Premium and Health FSA benefits only)*

[ ] Court order requiring coverage for Dependent on ___/___/___

4. Medicare or Medicaid *(applies to Premium and Health FSA benefits only)*

[ ] Became eligible for Medicare or Medicaid on ___/___/___

[ ] Became ineligible for Medicare or Medicaid on ___/___/___

5. Change in Cost *(applies to Premium and Dependent Care FSA benefits only)*

[ ] Significant cost increase in coverage on ___/___/___

[ ] Significant cost decrease in coverage on ___/___/___

6. Change in Coverage *(applies to Premium and Dependent Care FSA benefits only)*

[ ] Change in dependent care provider on ___/___/___

[ ] Significant curtailment of coverage on ___/___/___

[ ] Addition or significant improvement of a plan option on ___/___/___

[ ] Loss of group health coverage under plan of a governmental or educational institution on ___/___/___

[ ] Change in coverage under an employer's plan on ___/___/___

Signature

I have examined this authorization to modify my Salary Reduction Agreement and to the best of my knowledge, it is true, correct and complete. I understand that the election change I have requested must be on account of and consistent with the status change or other election change event (s) I have checked above. I understand that the status and participation changes must comply with the Plan and that the Plan Administrator has the sole discretion in making this determination. I further understand that I may be required to provide documentation regarding the change(s) I have checked above.

_____ _____

Participant's Signature Date

Sec 132 and Sec 125 FSAs must indicate the LAST PAY DATE affected (may differ from actual Termination Date): _____/_____/_____

Denied by _____ on _____

Reason for Denial _____

Action to be taken_____

*Plan Administrator*_____ _____

Agreed and accepted by the Employer's Representative Date

SECTION 5

ADMINISTRATION GUIDE &

NON-DISCRIMINATION TESTING

PLACE ALL PAGES AFTER TAB 5

RETAIN TO REFERENCE NEW REGULATIONS AS NEEDED

HOW TO ADOPT THE HEALTH FSA CARRYOVER OF UNUSED BENEFITS

The IRS allows Employers to modify the Health FSA "use it or lose it" rule by amending their Health FSA to allow a carryover of up to $680.00 of unused FSA balances from one Plan Year to the next Plan Year, provided the Health FSA does not also include the Grace Period rule. If the Health FSA Carryover is adopted, participants with an FSA balance remaining at the end of the Plan Year will be able to use those unused funds for the reimbursement of qualifying medical expenses incurred in the next Plan Year. The carryover option does not affect the maximum amount of salary reduction contributions the participant is permitted to make under the Health FSA Plan.

An Employer is not required to adopt the Health FSA Carryover, but Employers who wish to adopt the Health FSA Carryover for their current Plan Year must amend their Plan before the end of that Plan Year.

The template on the following page can be used to Amend your Plan to adopt the Health FSA Carryover for the current Plan Year.

Should you choose to amend your Plan to adopt the Health FSA Carryover:

1. Complete the "Amendment Adopting Health FSA Carryover" and place it in Section 1 of your Plan Document, in front of the Resolution to Adopt the Plan and any previous Amendments.
2. Complete the Summary of Material Modifications (SMM); distribute a copy to each eligible Employee; place a copy at the end of your Plan Document and at the end of your Summary Plan Description. **You must notify Plan participants of the Health FSA Carryover prior to the end of the Plan Year.**

CITY OF LUVERNE

AMENDMENT ADDING HEALTH FSA CARRYOVER

IRC SECTION 125 CAFETERIA PLAN

As Permitted by IRS Notice 2013-71

WHEREAS, City of Luverne has determined that it would be in the best interests of its employees to adopt the Health FSA Carryover for their "Section 125 Health Flexible Spending Account" as permitted by IRS Notice 2013-71, so-called; be it known that a vote was taken, and all were in favor to amend said Plan herein, to be effective for the current Plan Year.

RESOLVED, that City of Luverne amend its so-called "Section 125 Health FSA Plan", all in accordance with the specifications annexed hereto; and, be it known that the amended “Health FSA Plan" Document was executed _____, 20__. These amendments shall apply notwithstanding any other statements in the Plan, the summary plan description (SPD), or any other documents for the current Plan Year.

RESOLVED FURTHER, that City of Luverne undertake all actions necessary to implement and administer said amendment.

IN WITNESS WHEREOF, I have executed my name for City of Luverne on _____, 20__.

ATTEST:

_____ By: _____

Witness Jill Wolf

CITY OF LUVERNE

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) CARRYOVER

SUMMARY OF MATERIAL MODIFICATIONS

PURPOSE

The Health FSA (the "Plan"), adopted by City of Luverne on January 1, 1991, is herein amended effective _____, 20__ to adopt the Health FSA Carryover for the current Plan Year. The Health FSA Carryover option will begin on January 1, 20__ and will end on December 31, 20__. The Health FSA Carryover option will allow up to $680.00 of unused amounts remaining in your Health FSA Account on December 31, 20__, to be used to reimburse you for eligible medical expenses incurred in the following Plan Year.

A. Plan Amendments

1. The Health FSA Carryover option for Health FSA Component:

Amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses that are incurred during subsequent Plan Years under the following conditions:

(a) Applicability.

In order for an individual to be reimbursed for Medical Care Expenses from amounts remaining in his or her Health FSA Account at the end of the Plan Year, he or she must be either (1) an eligible Employee; or (2) a qualified beneficiary (as defined under COBRA) who has COBRA coverage under the Health FSA Component on the last day of that Plan Year.

(b) No Cash-Out or Conversion.

Unused Health FSA balances may not be cashed out or converted to any other taxable or nontaxable benefit. For example, unused Health FSA Amounts may not be used to reimburse Dependent Care Expenses.

(c) Reimbursement of Health FSA expenses.

The unused Health FSA balance at the end of the prior Plan Year may be used for expenses incurred in the prior Plan Year if claimed during the Plan's run-out period, or to expenses that are incurred at any time in the current Plan Year. Medical Care Expenses incurred during the current Plan Year and approved for reimbursement in accordance with the Plan's claims procedure for the Health FSA Component will be reimbursed and charged first against the current Plan Year Health FSA Amounts. All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

(d) Run-Out Period and Forfeitures.

Claims for reimbursement of Medical Care Expenses incurred during a Plan Year must be submitted no later than 90 days following the close of the Plan Year in order to be reimbursed from the prior Plan Year Health FSA Amounts. Any prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year shall be carried over to reimburse the Participant for expenses incurred in the following Plan Year. The Participant will forfeit all rights with respect to

such balance, upon termination of employment, unless FSA COBRA coverage has been selected. Unused Health FSA balances in excess of $680.00 will be forfeited.

(e) **Debit Cards** *(if applicable).*
If a Debit Card is provided to access your Health FSA funds, verify with your Plan Administrator whether you may use your Debit Card to access amounts available from the Prior Plan Year Health FSA.

Caution Regarding Impact of Health FSA Carryover on Eligibility to Contribute to a Health Savings Account (HSA).

Under IRS rules regarding Health FSA and an Employee's ability to contribute to a Health Savings Account (HSA), the Employee may be restricted to Health FSA reimbursement of eligible dental, vision, or preventive care expenses only, unless the HSA compatible health insurance plan statutory minimum deductible amount has been met. The Employee should check with their HSA Administrator and/or Plan Administrator.

Please attach this document to your SPD for future reference.

If you have questions, please contact the Plan Administrator.

City of Luverne

305 E. Luverne St.; P.O. Box 659

Luverne, MN 56156

Tel. 507-449-2388

Plan Sponsor: City of Luverne

Sponsor's EIN: 41-6005329

Plan Name: City of Luverne Health FSA

Plan Number: 501

Plan Year: January 1 to December 31

Employee Benefits--Cafeteria Plans; Proposed Rule
REG-142695-05 – August 6, 2007

Department of the Treasury
Internal Revenue Service
26 CFR Part 1
REG-142695-05
Employee Benefits--Cafeteria Plans
AGENCY: Internal Revenue Service (IRS), Treasury.
ACTION: Withdrawal of prior notices of proposed rulemaking, notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains new proposed regulations providing guidance on cafeteria plans. This document also withdraws the notices of proposed rulemaking relating to cafeteria plans under section 125 that were published on May 7, 1984, December 31, 1984, March 7, 1989, November 7, 1997 and March 23, 2000. In general, these proposed regulations would affect employers that sponsor a cafeteria plan, employees that participate in a cafeteria plan, and third party cafeteria plan administrators.

Explanation of Provisions

Overview
The new proposed regulations are organized as follows: general rules on qualified and nonqualified benefits in cafeteria plans (new proposed Sec. 1.125-1), general rules on elections (new proposed Sec. 1.125-2), general rules on flexible spending arrangements (new proposed Sec. 1.125-5), general rules on substantiation of expenses for qualified benefits (new proposed Sec. 1.125-6) and nondiscrimination rules (new proposed Sec. 1.125-7). The new proposed regulations, new Proposed Sec. Sec. 1.125-1, 1.125-2, 1.125-5, 1.125-6 and Sec. 1.125-7, consolidate and restate Proposed Sec. 1.125-1 (1984, 1997, 2000), Sec. 1.125-2 (1989, 1997, 2000) and Sec. 1.125-2T (1986). Unless otherwise indicated, references to “new proposed regulations” or “these proposed regulations” mean the proposed section 125 regulations being published in this document.

The new proposed regulations reflect changes in tax law since the prior regulations were proposed, including: the change in the definition of dependent (section 152) and the addition of the following as qualified benefits: adoption assistance (section 137), additional deferred compensation benefits described in section 125(d)(1)(B), (C) and (D), Health Savings Accounts (HSAs) (sections 223, 125(d)(2)(D) and 4980G), and qualified HSA distributions from health FSAs (section 106(e)). Other changes include the prohibition against long-term care insurance and long-term care services (section 125(f)) and the addition of the key employee concentration test in section 125(b)(2).

The prior proposed regulations, Sec. Sec. 1.125-1 and 1.125-2, provide the basic framework and requirements for cafeteria plans and elections under cafeteria plans. The prior proposed regulations also outlined the most significant rules for benefits under a health flexible spending arrangement (health FSA) offered by a cafeteria plan--the requirement that the maximum reimbursement be available at all times during the coverage period (the uniform coverage rule), the requirement of a 12-month period of coverage, the requirement that the health FSA only reimburse medical expenses, the requirement that all medical expenses be substantiated by a third party before reimbursement, the requirement that expenses be incurred during the period of coverage, and the prohibition against deferral of compensation (including the use-or-lose rule). The prior proposed regulations also provided guidelines for dependent care FSAs, and the application of section 125 to paid vacation days offered under a cafeteria plan. These remain substantially unchanged in the new proposed regulations, with certain clarifications. Finally, the prior proposed regulations included a number of Q & As addressing transitional issues relating to the enactment of section 125, as well as the application of the now-repealed section 89 (special nondiscrimination rules with respect to certain employee benefit plans). These provisions are omitted from the new proposed regulations.

I. New Proposed Sec. 1.125-1--Qualified and Nonqualified Benefits in Cafeteria Plans Section 125 Exclusive Noninclusion Rule
Section 125 provides that, except in the case of certain discriminatory benefits, no amount shall be included in the gross income of a participant in a cafeteria plan (as defined in section 125(d)) solely because, under the plan, the participant may choose among the benefits of the plan. The new proposed regulations clarify and amplify the general rule in the prior proposed regulations that section 125 is the exclusive means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice itself resulting in inclusion in gross income by the

employees. When employees may elect between taxable and nontaxable benefits, this election results in gross income to employees, unless a specific Internal Revenue Code (Code) section (such as section 125) intervenes to prevent gross income inclusion. Thus, except for an election made through a cafeteria plan that satisfies section 125 or another specific Code section (such as section 132(f)(4)), any opportunity to elect among taxable and nontaxable benefits results in inclusion of the taxable benefit regardless of what benefit is elected and when the election is made. This interpretation of section 125 is consistent with the legislative history of section 125. The legislative history begins with the interim ERISA rules for cafeteria plans:

Under * * * ERISA, an employer contribution made before January 1, 1977, to a cafeteria plan in existence on June 27, 1974, is required to be included in an employees' gross income only to the extent that the employee actually elects taxable benefits. In the case of a plan not in existence on June 27, 1974, the employer contribution is required to be included in an employee's gross income to the extent the employee could have elected taxable benefits. S. Rep. No. 1263, 95th Cong., 2d Sess. 74 (1978), reprinted in 1978 U.S.C.C.A.N. 6837; H. R. Rep. No. 1445, 95th Cong., 2d Sess. 63 (1978); H.R. Conf. Rep. No. 1800, 95th Cong., 2d Sess. 206 (1978).

The legislative history also provides:

Generally, employer contributions under a written cafeteria plan which permits employees to elect between taxable and nontaxable benefits are excluded from the gross income of an employee to the extent that nontaxable benefits are elected. S. Rep. No. 1263, 95th Cong., 2d Sess. 75 (1978), reprinted in 1978 U.S.C.C.A.N. 6838; H. R. Rep. No. 1445, 95th Cong., 2d Sess. 63 (1978). See also H.R. Conf. Rep. No. 1800, 95th Cong., 2d Sess. 206 (1978).

The legislative history to the 1984 amendments to section 125 continues:

The cafeteria plan rules of the Code provide that a participant in a nondiscriminatory cafeteria plan will not be treated as having received a taxable benefit offered under the plan solely because the participant has the opportunity, before the benefit becomes available, to choose among the taxable and nontaxable benefits under the plan. H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1173 (1984), reprinted in 1984 U.S.C.C.A.N. 1861. See also H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 295, reprinted in 1996 U.S.C.C.A.N. 2108.

The new proposed regulations provide that unless a plan satisfies the requirements of section 125 and the regulations, the plan is not a cafeteria plan. Reasons that a plan would fail to satisfy the section 125 requirements include: Offering nonqualified benefits; not offering an election between at least one permitted taxable benefit and at least one qualified benefit; deferring compensation; failing to comply with the uniform coverage rule or use-or-lose rule; allowing employees to revoke elections or make new elections during a plan year, except as provided in Sec. 1.125-4; failing to comply with substantiation requirements; paying or reimbursing expenses incurred for qualified benefits before the effective date of the cafeteria plan or before a period of coverage; allocating experience gains (forfeitures) other than as expressly allowed in the new proposed regulations; and failing to comply with grace period rules.

Definition of a Cafeteria Plan

The new proposed regulations provide that a cafeteria plan is a separate written plan that complies with the requirements of section 125 and the regulations, that is maintained by an employer for employees and that is operated in compliance with the requirements of section 125 and the regulations. Participants in a cafeteria plan must be permitted to choose among at least one permitted taxable benefit (for example, cash, including salary reduction) and at least one qualified benefit. A plan offering only elections among nontaxable benefits is not a cafeteria plan. Also, a plan offering only elections among taxable benefits is not a cafeteria plan. See Rev. Rul. 2002-27, Situation 2 (2002-1 CB 925), see Sec. 601.601(d)(2)(ii)(b). Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in section 125(d)(2)(B), (C), or (D).

Written Plan

Section 125(d)(1) requires that a cafeteria plan be in writing. The cafeteria plan must be operated in accordance with the written plan terms. The new proposed regulations require that the written plan specifically describe all benefits, set forth the rules for eligibility to participate and the procedure for making elections, provide that all elections are irrevocable (except to the extent that the plan includes the optional change in status rules in Sec. 1.125-4), and state how employer contributions may be made under the plan (for example, salary reduction or nonelective employer contributions), the maximum amount of elective contributions, and the plan year. If the plan includes a flexible spending arrangement (FSA), the written plan must include provisions complying with the uniform coverage rule and the use-or-lose rule. Because

section 125(d)(1)(A) states that a cafeteria plan is a written plan under which "all participants are employees", the new proposed regulations require that the written cafeteria plan specify that only employees may participate in the cafeteria plan. The new proposed regulations also require that all provisions of the written plan apply uniformly to all participants.

Individuals Who May Participate in a Cafeteria Plan
All participants in a cafeteria plan must be employees. See section 125(d)(1)(A). These proposed regulations provide that employees include common law employees, leased employees described in section 414(n), and full-time life insurance salesmen (as defined in section 7701(a)(20)). These proposed regulations further provide that former employees (including laid-off employees and retired employees) may participate in a plan, but a plan may not be maintained predominantly for former employees. See Rev. Rul. 82-196 (1982-2 CB 53); Rev. Rul. 85-121 (1985-2 CB 57), see Sec. 601.601(d)(2)(ii)(b). All employees who are treated as employed by a single employer under section 414(b), (c) or (m) are treated as employed by a single employer for purposes of section 125. See section 125(g)(4). A participant's spouse or dependents may receive benefits through a cafeteria plan although they cannot participate in the cafeteria plan. Self-employed individuals are not treated as employees for purposes of section 125. Accordingly, the new proposed regulations make clear that sole proprietors, partners, and directors of corporations are not employees and may not participate in a cafeteria plan. In addition, the new proposed regulations clarify that 2-percent shareholders of an S corporation are not employees for purposes of section 125. The new proposed regulations provide rules for dual status individuals and individuals moving between employee and non-employee status. A self-employed individual may, however, sponsor a cafeteria plan for his or her employees.

Election Between Taxable and Nontaxable Benefits
The new proposed regulations require that a cafeteria plan offer employees an election among only permitted taxable benefits (including cash) and qualified nontaxable benefits. See section 125(d)(1)(B). For purposes of section 125, cash means cash from current compensation (including salary reduction), payment for annual leave, sick leave, or other paid time off, severance pay, property, and certain after-tax employee contributions. Distributions from qualified retirement plans are not cash or taxable benefits for purposes of section 125. See Rev. Rul. 2003-62 (2003-1 CB 1034) (distributions to former employees from a qualified employees' trust, applied to pay health insurance premiums, are includible in former employees' gross income under section 402), see Sec. 601.601(d)(2)(ii)(b).

Qualified Benefits
In general, in order for a benefit to be a qualified benefit for purposes of section 125, the benefit must be excludible from employees' gross income under a specific provision of the Code and must not defer compensation, except as specifically allowed in section 125(d)(2)(B), (C) or (D). Examples of qualified benefits include the following: group-term life insurance on the life of an employee (section 79); employer-provided accident and health plans, including health flexible spending arrangements, and accidental death and dismemberment policies (sections 106 and 105(b)); a dependent care assistance program (section 129); an adoption assistance program (section 137); contributions to a section 401(k) plan; contributions to certain plans maintained by educational organizations, and contributions to HSAs. Section 125(f), (d)(2)(B), (C), (D). See Notice 97-9 (1997-2 CB 35) (adoption assistance), see Sec. 601.601(d)(2)(ii)(b); Notice 2004-2, Q & A-33 (2004-1 CB 269) (HSAs), see Sec. 601.601(d)(2)(ii)(b). A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). However, see paragraph (q) in Sec. 1.125-1 for nonqualified benefits.

Group-Term Life Insurance
An employer may provide group-term life insurance through a combination of methods. Generally, under section 79(a), the cost of $50,000 or less of group-term life insurance on the life of an employee provided under a policy (or policies) carried directly or indirectly by an employer is excludible from the employee's gross income. (Special rules apply to key employees if the group-term life insurance plan does not satisfy the nondiscrimination rules in section 79(d)). However, if the group-term life insurance provided to an employee by an employer or employers exceeds $50,000 (taking into account all coverage provided both through a cafeteria plan and outside a cafeteria plan), the cost of coverage exceeding coverage of $50,000 is includible in the employee's gross income. For this purpose, the cost of group-term life insurance is shown in Sec. 1.79-3(d)(2), Table I (Table I). The Table I cost of the excess group-term life insurance (minus all after-tax contributions by the employee for group-term life insurance coverage) is includible in each covered employee's gross income. The new proposed regulations provide that the cost of group-term life insurance on the life of an employee, that either is less than or equal to the amount excludible from gross income under section 79(a) or provides coverage in excess of that amount, but not combined with any permanent benefit, is a qualified benefit that may be offered in a cafeteria plan. The new proposed regulations also provide that the entire amount of salary reduction and employer flex credits for group-term life insurance coverage on the life of an employee is excludible from an employee's gross income.

The rule in the new proposed regulations differs from Notice 89-110 (1989-2 CB 447), see Sec. 601.601(d)(2)(ii)(b). Notice 89-110 provides that an employee includes in gross income the greater of the Table I cost of group-term life insurance coverage exceeding $50,000 or the employee's salary reduction and employer flex-credits for excess group term life insurance coverage. The new proposed regulations provide instead that the employee includes in gross income the Table I cost of the excess coverage (minus all after-tax contributions by the employee for group-term life insurance coverage) and that the entire amount of salary reduction and employer flex-credits for group-term life insurance coverage on the life of the employee is excludible from the employee's gross income. As noted in this preamble, taxpayers may rely on the new proposed regulations for guidance pending the issuance of final regulations.

Employer-Provided Accident and Health Plan
Coverage under an employer-provided accident and health plan that satisfies the requirements of section 105(b) may be provided as a qualified benefit through a cafeteria plan and is excludible from employees' gross income. Section 106; Sec. 1.106-1. The nondiscrimination rules under section 105(h) apply to self-insured medical reimbursement arrangements (including health FSAs).

The new proposed regulations specifically permit a cafeteria plan (but not a health FSA) to pay or reimburse substantiated individual accident and health insurance premiums. See Rev. Rul. 61-146 (1961-2 CB 25), see Sec. 601.601(d)(2)(ii)(b). In addition, a cafeteria plan may provide for payment of COBRA premiums for an employee. For employer-provided accident and health plans and medical reimbursement plans, the definition of dependents is the definition in section 105(b) as amended by the Working Families Tax Relief Act of 2004 (WFTRA), Public Law 108-311, section 207(9) (118 Stat. 1166) (that is, a dependent as defined in section 152, determined without regard to section 152(b)(1), (b)(2), or (d)(1)(B)). See Notice 2004-79 (2004-2 CB 898), see Sec. 601.601(d)(2)(ii)(b). For purposes of the exclusion from employees' gross income for accident and health plans and for medical reimbursement under sections 105(b) and 106, the spouse or dependent of a former employee (including a retired employee or a laid-off employee) or of a deceased employee is treated as a spouse or dependent. See Rev. Rul. 82-196 (1982-2 CB 53); Rev. Rul. 85-121 (1985-2 CB 57), see Sec. 601.601(d)(2)(ii)(b).

Dependent Care Assistance Programs and Adoption Assistance Programs
If the requirements of section 129 are satisfied, up to $5,000 of employer-provided assistance for amounts paid or incurred by employees for dependent care is excludible from employees' gross income. The new proposed regulations outline the general requirements for providing dependent care assistance programs and adoption assistance programs under section 137 through a cafeteria plan. See Notice 97-9, section II (1997-2 CB 35), see Sec. 01.601(d)(2)(ii)(b) Cafeteria Plan Year. The new proposed regulations require that a cafeteria plan year must be 12 consecutive months and must be set out in the written cafeteria plan. A short plan year (or a change in plan year resulting in a short plan year) is permitted only for a valid business purpose. A change in plan year resulting in a short plan year, for other than a valid business purpose, is disregarded. If a principal purpose of a change in plan year is to circumvent the rules of section 125, the change in plan year is ineffective.

No Deferral of Compensation
Qualified benefits must be current benefits. In general, a cafeteria plan may not offer benefits that defer compensation or operate to defer compensation. Section 125(d)(2)(A). In general, benefits may not be carried over to a later plan year or used in one plan year to purchase benefits to be provided in a later plan year. For example, life insurance with a cash value build-up or group-term life insurance with a permanent benefit (within the meaning of Sec. 1.79-0) defers the receipt of compensation and thus is not a qualified benefit.

The new proposed regulations clarify whether certain benefits and plan administration practices defer compensation. For example, the regulations permit an accident and health insurance policy to provide certain benefit features that apply for more than one plan year, such as reasonable lifetime limits on benefits, level premiums, premium waiver during disability, guaranteed renewability of coverage, coverage for specified accidental injury or specific diseases, and the payment of a fixed amount per day for hospitalization. But these insurance policies must not provide an investment fund or cash value to pay premiums, and no part of the premium may be held in a separate account for any beneficiary. The new proposed regulations also provide that the following benefits and practices do not defer compensation: a long-term disability policy paying benefits over more than one plan year; reasonable premium rebates or policy dividends; certain two-year lock-in vision and dental policies; certain advance payments for orthodontia; salary reduction contributions in the last month of a plan year used to pay accident and health insurance premiums for the first month of the following plan year; reimbursement of section 213(d) expenses for durable medical equipment; and allocation of experience gains (forfeitures) among participants.

Paid Time Off
Under the prior proposed regulations, permitted taxable benefits included various forms of paid leave. Since the prior proposed regulations were issued, many employers have recharacterized and combined vacation days, sick leave and personal days into a single category of "paid time off." The new proposed regulations use the term "paid time off"' to refer to vacation days and other types of paid leave. The new proposed regulations contain the same ordering rule for elective and nonelective paid time off as set forth in Prop. Sec. 1.125-1, Q & A-7 (1984). A plan offering an election solely between paid time off and taxable benefits is not a cafeteria plan.

Grace Period
The new proposed regulations allow a written cafeteria plan to provide an optional grace period immediately following the end of each plan year, extending the period for incurring expenses for qualified benefits. A grace period may apply to one or more qualified benefits (for example, health FSA or dependent care assistance program) but in no event does it apply to paid time off or contributions to section 401(k) plans. Unused benefits or contributions for one qualified benefit may only be used to reimburse expenses incurred during the grace period for that same qualified benefit. The amount of unused benefits and contributions available during the grace period may be limited by the employer. A grace period may extend to the fifteenth day of the third month after the end of the plan year (but may be for a shorter period). Benefits or contributions not used as of the end of the grace period are forfeited under the use-or-lose rule. The grace period applies to all employees who are participants (including through COBRA), as of the last day of the plan year. Grace period rules must apply uniformly to all participants. The grace period rules in these proposed regulations are based on Notice 2005-42 (2005-1 CB 1204), modified in Notice 2007-22 (2007-10 IRB 670), see Sec. 601.601(d)(2)(ii)(b), amplified in Notice 2005-86 (2005-2 CB 1075), amplified in Notice 2007-22 (2007-10 IRB 670), see Sec. 601.601(d)(2)(ii)(b). For eligibility to contribute to a Health Savings Account (HSA) during a grace period, see Notice 2005-86 (2005-2 CB 1075), see Sec. 601.601(d)(2)(ii)(b). For Form W-2 reporting for unused dependent care assistance used for expenses incurred during a grace period, see Notice 2005-61 (2005-2 CB 607), see Sec. 601.601(d)(2)(ii)(b).

Contributions to Section 401(k) Plans Through a Cafeteria Plan
A cafeteria plan may include contributions to a section 401(k) plan. Section 125(d)(2)(B). The new proposed regulations clarify the interactions between section 125 and section 401(k). Contributions to a section 401(k) plan expressed as a percentage of compensation are permitted. Pursuant to Sec. 1.401(k)-1(a)(3)(ii), elective contributions to a section 401(k) plan may be made through automatic enrollment (that is, when the employee does not affirmatively elect cash, the employee's compensation is reduced by a fixed percentage, which is contributed to a section 401(k) plan).

Nonqualified Benefits
A cafeteria plan must not offer any of the following benefits: scholarships (section 117); employer-provided meals and lodging (section 119); educational assistance (section 127); fringe benefits (section 132); long-term care insurance. See section 125(f). Long-term care services are nonqualified benefits, H.R. Conf. Rep. No. 736, 104th Cong., 2d Sess. 29, reprinted in 1996 U.S.C.C.A.N. 2109. (An HSA funded through a cafeteria plan may, however, be used to pay premiums for long-term care insurance or for long-term care services.) The new proposed regulations clarify that contributions to Archer Medical Savings Accounts (sections 220, 106(b)), group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits. A plan offering any nonqualified benefit is not a cafeteria plan. A cafeteria plan may not offer a health FSA that provides for the carryover of unused benefits. See Notice 2002-45, Part I (2002-2 CB 93); Rev. Rul. 2002-41 (2002-2 CB 75), see Sec. 601.601(d)(2)(ii)(b).

After-Tax Employee Contributions
The new proposed regulations allow a cafeteria plan to offer after-tax employee contributions for qualified benefits or paid time off. A cafeteria plan may only offer the taxable benefits specifically permitted in the new proposed regulations. Nonqualified benefits may not be offered through a cafeteria plan, even if paid with after-tax employee contributions.

Employer Contributions Through Salary Reduction
Employees electing a qualified benefit through salary reduction are electing to forego salary and instead to receive a benefit which is excludible from gross income because it is provided by employer contributions. Section 125 provides that the employee is treated as receiving the qualified benefit from the employer in lieu of the taxable benefit. A cafeteria plan may also impose reasonable fees to administer the cafeteria plan which may be paid through salary reduction. A cafeteria plan is not required to allow employees to pay for any qualified benefit with after-tax employee contributions.

II. New Prop. Sec. 1.125-2--Elections in Cafeteria Plans

Making, Revoking and Changing Elections

Generally, a cafeteria plan must require employees to elect annually between taxable benefits and qualified benefits. Elections must be made before the earlier of the first day of the period of coverage or when benefits are first currently available. The determination of whether a taxable benefit is currently available does not depend on whether it has been constructively received by the employee for purposes of section 451. Annual elections generally must be irrevocable and may not be changed during the plan year. However, Sec. 1.125-4 permits a cafeteria plan to provide for changes in elections based on certain changes in status. An employer that wishes to permit such changes in elections must incorporate the rules in Sec. 1.125-4 in its written cafeteria plan. These proposed regulations omit the rule in Q & A-6(b) in Prop. Sec. 1.125-2 (1989) (cessation of required contributions), because the change in status rules in Sec. 1.125-4 superseded this provision of the 1989 proposed regulations.

If HSA contributions are made through salary reduction under a cafeteria plan, employees may prospectively elect, revoke or change salary reduction elections for HSA contributions at any time during the plan year with respect to salary that has not become currently available at the time of the election.

A cafeteria plan is permitted to include an automatic election for new employees or current employees. Rev. Rul. 2002-27 (2002-1 CB 925), see Sec. 601.601(d)(2)(ii)(b). A new rule also permits a cafeteria plan to provide an optional election for new employees between cash and qualified benefits. New employees avoid gross income inclusion if they make an election within 30 days after the date of hire even if benefits provided pursuant to the election relate back to the date of hire. However, salary reduction amounts used to pay for such an election must be from compensation not yet currently available on the date of the election. Also, this special election rule for new employees does not apply to any employee who terminates employment and is rehired within 30 days after terminating employment (or who returns to employment following an unpaid leave of absence of less than 30 days).

New elections and revocations or changes in elections can be made electronically. The safe harbor for electronic elections in Sec. 1.401(a)-21 is available. Only an employee can make an election or revoke or change his or her election. An employee's spouse or dependent may not make an election under a cafeteria plan and may not revoke or change an employee's election.

III. New Prop. Sec. 1.125-5--Flexible Spending Arrangements

Overview

In general, a flexible spending arrangement (FSA) is a benefit designed to reimburse employees for expenses incurred for certain qualified benefits, up to a maximum amount not substantially in excess of the salary reduction and employer flex-credits allocated for the benefit. The maximum amount of reimbursement reasonably available must be less than five times the value of the coverage. Employer flex-credits are non-elective employer contributions that an employer makes available for every employee eligible to participate in the cafeteria plan, to be used at the employee's election only for one or more qualified benefits (but not as cash or other taxable benefits). The three types of FSAs are dependent care assistance, adoption assistance and medical care reimbursements (health FSA).

Uniform Coverage Rule

The new proposed regulations retain the rule that the maximum amount of reimbursement from a health FSA must be available at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements). The uniform coverage rule does not apply to FSAs for dependent care assistance or adoption assistance.

Use-or-Lose Rule

An FSA must satisfy all the requirements of section 125, including the prohibition against deferring compensation. In general, as discussed under "no deferral of compensation", in order to satisfy this requirement of section 125, all benefits and contributions must be used by the end of the plan year (or grace period, if applicable), or are forfeited. The new proposed regulations continue the use-or-lose rule.

Period of Coverage

The required period of coverage for all FSAs continues to be twelve months, with an exception for short plan years that satisfy the conditions in the new proposed regulations. The period of coverage and the plan year need not be the same. The beginning and end of a period of coverage is clarified. The new proposed regulations also clarify that FSAs for

different qualified benefits need not have the same coverage period. See also “Grace period”, discussed in this preamble. The new proposed regulations also continue to provide that expenses are incurred when services are provided. Expenses incurred before or after the period of coverage may not be reimbursed.

Health FSA
A health FSA may only reimburse certain substantiated section 213(d) medical care expenses incurred by the employee, or by the employee’s spouse or dependents. A health FSA may be limited to a subset of permitted section 213(d) medical expenses (for example, a health FSA is permitted to exclude reimbursement of over-the-counter drugs described in Rev. Rul. 2003-102 (2003-2 CB 559), see Sec. 601.601(d)(2)(ii)(b)). Similarly, a health FSA may be an HSA compatible limited-purpose health FSA or post-deductible health FSA. Rev. Rul. 2004-45 (2004-1 CB 971), see Sec. 601.601(d)(2)(ii)(b), amplified, Notice 2005-86 (2005-2 CB 1075). A health FSA may not reimburse premiums for accident and health insurance or long-term care insurance. See section 125(f).

A health FSA must satisfy all requirements of section 105(b), Sec. Sec. 1.105-1 and 1.105-2. The section 105(h) nondiscrimination rules apply to health FSAs. All medical expenses must be substantiated before expenses are reimbursed. See Incurring and reimbursing expenses for qualified benefits, discussed in this preamble. The new proposed regulations also clarify when medical expenses are incurred.\1\ A cafeteria plan may limit enrollment in a health FSA to those employees who participate in the employer’s accident and health plan.

\1\ See Rev. Rul. 2005-55 (2005-2 CB 284) and Rev. Rul. 2005-24 (2005-1 CB 892), see Sec. 601.601(d)(2)(ii)(b) (section 105(b) exclusion only applicable to reimbursements for medical expenses incurred by employee, or by the employee’s spouse or dependents); Rev. Rul. 2002-3 (2002-1 CB 316) (purported reimbursements to employees of health insurance premiums not paid by employees and therefore impermissible); Rev. Rul. 2002-80 (2002-2 CB 925), see Sec. 601.601(d)(2)(ii)(b) (so-called advance reimbursements and purported loans are impermissible); Rev. Rul. 2003-43 (2003-1 CB 935), see Sec. 601.601(d)(2)(ii)(b); Notice 2006-69 (2006-31 IRB 107) (substantiation requirements for debit cards), amplified in Notice 2007-2 (2007-2 IRB 254), see Sec. 601.601(d)(2)(ii)(b).

Qualified HSA Distributions
Section 106(e), enacted in section 302 of the Health Opportunity Patient Empowerment Act of 2006, Public Law 109-432 (120 Stat. 2922 (2006)) allows “qualified HSA distributions” from health FSAs to HSAs. Section 106(e) applies to distributions between December 20, 2006 and December 31, 2011. The proposed regulations incorporate the rules on qualified HSA distributions set forth in Notice 2007-22 (2007-10 IRB 670). See Sec. 601.601(d)(2)(ii)(b).

The distribution must not be more than the lesser of the balance in the health FSA on September 21, 2006, or the date of the distribution. If you were not covered by a health FSA on September 21, 2006, you cannot elect to make a qualified HSA distribution from the health FSA. If you were covered by a health FSA with an employer on September 21, 2006, but change employers after that date, you cannot elect to make a qualified HSA distribution from your second employer's health FSA.

The following conditions must be met to make a qualified HSA distribution.
-The plan must have been amended to allow these distributions.
-You must elect to make the rollover.
-The year-end balance in the health FSA must be frozen.
-The funds must be transferred within 2½ months after the end of the health FSA's plan year and result in a zero balance in the health FSA.
-The distribution must be contributed directly to the HSA trustee by the employer.

Only one qualified HSA distribution is allowed for each health FSA. If you do not remain an eligible individual for HSA purposes during the testing period, the distribution is included in your income and is subject to a 10% additional tax. For more information, see Notice 2007-22, 2007-10 I.R.B. 670

Dependent Care Assistance After Termination
A new optional rule permits an employer to reimburse a terminated employee’s qualified dependent care expenses incurred after termination through a dependent care FSA, if all section 129 requirements are otherwise satisfied.

Experience Gains
If an employee fails to use all contributions and benefits for a plan year before the end of the plan year (and the grace period, if applicable), those unused contributions and benefits are forfeited under the use-or-lose rule. Unused amounts are also known as experience gains. The new proposed regulations retain the forfeiture allocation rules in the 1989 proposed regulations, and clarify that the employer sponsoring the cafeteria plan may retain forfeitures, use forfeitures to defray expenses of administering the plan or allocate forfeitures among employees contributing through salary reduction on a reasonable and uniform basis.

FSA Administrative Rules
Salary reduction contributions may be made at whatever interval the employer selects, including ratably over the plan year based on the employer's payroll periods or in equal installments at other regular intervals (for example, quarterly installments). These rules must apply uniformly to all participants.

IV. New Prop. Sec. 1.125-6--Substantiation of Expenses for All Cafeteria Plans

Incurring and Reimbursing Expenses for Qualified Benefits
The new proposed regulations provide that only expenses for qualified benefits incurred after the later of the effective date or the adoption date of the cafeteria plan are permitted to be reimbursed under the cafeteria plan. Similarly, if a plan amendment adds a new qualified benefit, only expenses incurred after the later of the effective date or the adoption date are eligible for reimbursement.\2\ This rule applies to all qualified benefits. Similarly, a cafeteria plan may pay or reimburse only expenses for qualified benefits incurred during a participant's period of coverage.

\2\ See American Family Mut. Ins. Co. v. United States, 815 F. Supp. 1206 (W.D. Wis. 1992); Wollenberg v. United States, 75 F. Supp.2d 1032 (D. Neb. 1999); Rev. Rul. 2002-58 (2002-2 CB 541), see Sec. 601.601(d)(2)(ii)(b); Notice 97-9, section II (adoption assistance).

Substantiation and Reimbursement of Expenses for Qualified Benefits
The new proposed regulations provide, after an employee incurs an expense for a qualified benefit during the coverage period, the expense must first be substantiated before the expense may be paid or reimbursed. All expenses must be substantiated (substantiating only a limited number of total claims, or not substantiating claims below a certain dollar amount does not satisfy the requirements in the new proposed regulations). See Sec. 1.105-2; Rul. 2003-80; Rev. Rul. 2003-43 (2002-1 CB 935), see Sec. 601.601(d)(2)(ii)(b); Notice 2006-69 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254). FSAs for dependent care assistance and adoption assistance must follow the substantiation procedures applicable to health FSAs.

Debit Cards
The new proposed regulations incorporate previously issued guidance on substantiating, paying and reimbursing expenses for section 213(d) medical care incurred at a medical care provider when payment is made with a debit card. Rev. Rul. 2003-43 (2003-1 CB 935), amplified, Notice 2006-69 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254); Rev. Proc. 98-25 (1998-1 CB 689), see Sec. 601.601(d)(2)(ii)(b). Among the permissible substantiation methods are copayment matches, recurring expenses, and real-time substantiation. The new proposed regulations also allow point-of sale substantiation through matching inventory information with a list of section 213(d) medical expenses. The employer is responsible for ensuring that the inventory information approval system complies with the new regulations and with the recordkeeping requirements in section 6001. Rev. Rul. 2003-43 (2003-1 CB 935), amplified, Notice 2006-69 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254); Rev. Proc. 98-25 (1998-1 CB 689), see Sec. 601.601(d)(2)(ii)(b). The new proposed regulations also provide rules under which an FSA may pay or reimburse dependent care expenses using debit cards.

Pursuant to prior guidance (in Notice 2006-69 (2006-31 IRB 107), amplified, Notice 2007-2 (2007-2 IRB 254)), for plan years beginning after December 31, 2006, the recordkeeping requirements described in paragraph (f) in Sec. 1.125-6 apply (that is, responsibility of employers relying on the inventory information approval system for health FSA debit cards to ensure that the system complies with the new proposed recordkeeping requirements, including Rev. Proc. 98-25 (1998- 1 CB 689), Notice 2006-69 (2006-31 IRB 107), amplified, Notice 2007-2 (2007-2 IRB 254). For health FSA debit card transactions occurring on or before December 31, 2007, all supermarkets, grocery stores, discount stores and wholesale clubs that do not have a medical care merchant category code (as described in Rev. Rul. 2003-43 (2003-2 CB 935) are nevertheless deemed to be an "other medical provider"' as described in Rev. Rul. 2003-43. (For a list of

merchant category codes, see Rev. Proc. 2004-43 (2004-2 CB 124).) During this time period, mail-order vendors and web-based vendors that sell prescription drugs are also deemed to be an "other medical provider" as described in Rev. Rul. 2003- 43. After December 31, 2008, health FSA debit cards may not be used at stores with the Drug Stores and Pharmacies merchant category code unless (1) the store participates in the inventory information approval system described in Notice 2006-69, or (2) on a store location by store location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care under section 213(d). Notice 2006-69 (2006-31 IRB 107), amplified, Notice 2007-2 (2007-2 IRB 254).

V. New Prop. Sec. 1.125-7--Nondiscrimination Rules

Discriminatory benefits provided to highly compensated participants and individuals and key employees are included in these employees' gross income. See section 125(b), (c). The new proposed regulations reflect changes in tax law since Prop. Sec. 1.125-1, Q & A-9 through 13 and 19 were proposed in 1984, including the key employee concentration test, statutory nontaxable benefits (enacted in the Deficit Reduction Act of 1984 (DEFRA), Public Law 98-369, section 531(b), (98 Stat. 881(1984)), and the change in definition of dependent in WFTRA.

The new proposed regulations provide additional guidance on the cafeteria plan nondiscrimination rules, including definitions of key terms, guidance on the eligibility test and the contributions and benefits tests, descriptions of employees allowed to be excluded from testing and a safe harbor nondiscrimination test for premium-only-plans.

Specifically, the new proposed regulations define several key terms, including highly compensated individual or participant (consistent with the section 414(q) definition of highly compensated employee), officer, five percent shareholder, key employee and compensation. The new proposed regulations also provide guidance on the non-discrimination as to eligibility requirement by incorporating some of the rules under section 410(b) (specifically the rules under Sec. 1.410(b)-4(b) and (c) dealing with reasonable classification, the safe harbor percentage test and the unsafe harbor percentage component of the facts and circumstances test).

The new proposed regulations also provide additional guidance on the contributions and benefits test and, unlike the prior proposed regulations, the new proposed regulations provide an objective test to determine when the actual election of benefits is discriminatory. Specifically, the new proposed regulations provide that a cafeteria plan must give each similarly situated participant a uniform opportunity to elect qualified benefits, and that highly compensated participants must not actually disproportionately elect qualified benefits. Finally, the new rules provide guidance on the safe harbor for cafeteria plans providing health benefits and create a safe harbor for premium-only-plans that satisfy certain requirements.

The example in Prop. Sec. 1.125-1, Q & A-11 (1984) is deleted because it concerns a qualified legal services plan, which is no longer a qualified benefit.

Other Issues

These proposed regulations provide guidance under section 125 (26 U.S.C. 125). Other statutes may impose additional requirements (for example, the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1000), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (sections 9801-9803); and the continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (section 4980B).

Proposed Effective Date

With the exceptions noted in the "Effect on other documents" section of this preamble and under the "Debit cards" section of the preamble, it is proposed that these regulations apply for plan years beginning on or after January 1, 2009. Taxpayers may rely on these regulations for guidance pending the issuance of final regulations. Prior published guidance on qualified benefits under sections 79, 105, 106, 129, 137 and 223 that is affected by these proposed regulations remains applicable through the effective date of the final regulations (except as modified in "Effect on other documents" section of this preamble).

Effect on Other Documents

Notice 89-110 (1989-2 CB 447), see Sec. 601.601(d)(2)(ii)(b), states that where group-term life insurance provided to an employee by an employer exceeds $50,000, the employee includes in gross income the greater of the cost of group-term life insurance shown in Sec. 1.79-3(d)(2), Table I (Table I) on the excess coverage or the employee's salary reduction and employer flex-credits for excess coverage. Notice 89-110 is modified, effective as of the date the proposed regulations are published in the Federal Register.

Published guidance under Sec. 105(b) states that if any person has the right to receive cash or any other taxable or nontaxable benefit under a health FSA other than the reimbursement of section 213(d) medical expenses of the employee, employee's spouse or employee's dependents, then all distributions made from the arrangement are included in the employee's gross income, even amounts paid to reimburse medical care. See Rev. Rul. 2006-36 (2006-36 IRB 353); Rev. Rul. 2005-24 (2005-1 CB 892); Rev. Rul. 2003-102 (2003-2 CB 559); Notice 2002-45 (2002-2 CB 93); Rev. Rul. 2002-41 (2002-2 CB 75); Rev. Rul. 69-141 (1969-1 CB 48). New section 106(e) provides that a health FSA will not fail to satisfy the requirements of sections 105 or 106 merely because the plan provides for a qualified HSA distribution. Amounts rolled into an HSA may be used for purposes other than reimbursing the section 213(d) medical expenses of the employee, spouse or dependents. Accordingly, Rev. Rul. 2006-36, Rev. Rul. 2005-24, Rev. Rul. 2003-102, Notice 2002-45, Rev. Rul. 2002-41, and Rev. Rul. 69-141 are modified with respect to qualified HSA distributions described in section 106(e). See Notice 2007-22 (2007-10 IRB 670), see Sec. 601.601(d)(2)(ii)(b).

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this regulation. It is hereby certified that the collection of information in this regulation will not have a significant economic impact on a substantial number of small entities. This certification is based on the fact that the regulations will only minimally increase the burdens on small entities. The requirements under these regulations relating to maintaining a section 125 cafeteria plan are a minimal additional burden independent of the burdens encompassed under existing rules for underlying employee benefit plans, which exist whether or not the benefits are provided through a cafeteria plan. In addition, most small entities that will maintain cafeteria plans already use a third-party plan administrator to administer the cafeteria plan. The collection of information required in these regulations, which is required to comply with the existing substantiation requirements of sections 105, 106, 129 and 125, and the recordkeeping requirements of section 6001, will only minimally increase the third-party administrator's burden with respect to the cafeteria plan. Therefore, an analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this proposed regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business. The rules of 26 CFR 601.601(a)(3) apply to the hearing. Persons who wish to present oral comments at the hearing

Simple Cafeteria Plan

After December 31, 2010, eligible employers meeting contribution requirements and eligibility and participation requirements can establish a simple cafeteria plan. Simple cafeteria plans are treated as meeting the nondiscrimination requirements of a cafeteria plan and certain benefits under a cafeteria plan.

Eligible Employer
You are an eligible employer if you employ an average of 100 or fewer employees during either of the two preceding years. If your business was not in existence throughout the preceding year, you are eligible if you reasonably expect to employ an average of 100 or fewer employees in the current year. If you establish a simple cafeteria plan in a year that you employ an average of 100 or fewer employees, you are considered an eligible employer for any subsequent year as long as you do not employ an average of 200 or more employees in a subsequent year.

Eligibility and Participation Requirements
These requirements are met if all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate and each employee eligible to participate in the plan may elect any benefit available under the plan. You may elect to exclude from the plan employees who:

1. Are under age 21 before the close of the plan year,
2. Have less than 1 year of service with you as of any day during the plan year,
3. Are covered under a collective bargaining agreement, or
4. Are nonresident aliens working outside the United States whose income did not come from a U.S. source.

Contribution Requirements
You must make a contribution to provide qualified benefits on behalf of each qualified employee in an amount equal to:

1. A uniform percentage (not less than 2%) of the employee's compensation for the plan year, or
2. An amount which is at least 6% of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee, whichever is less.

If the contribution requirements are met using option (2) above, the rate of contribution to any salary reduction contribution of a highly compensated or key employee can not be greater than the rate of contribution to any other employee.

(Publication 15-B 2011)

-If you have less than 100 employees;
-If employees that work 1,000 hours or more per year are eligible;
-If any eligible employee may choose any benefit available under the plan;
-If employees that have been employed by you one year (or less) are eligible;
-If employees over 21 are not excluded; and
-If you contribute either

1. A uniform percentage (not less than 2%) of the employee's compensation for the plan year, **or**
2. An amount which is at least 6% of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee, whichever is less. HCE salary reduction contribution cannot be greater than that of any other employee.

Then you have a **Simple Cafeteria Plan**! There is no need to perform Nondiscrimination testing.

Nondiscrimination

The proposed rules, for the first time in more than twenty years, try to elaborate on the application of various non-discrimination rules to cafeteria plans. Cafeteria plans cannot favor highly compensated individuals (HCIs) as to eligibility, or favor highly compensated participants as to contributions and benefits (Treas. Reg. §1.125-7). In applying this eligibility test, certain individuals are allowed to be disregarded, including COBRA qualified beneficiaries. In other words, the test is run based on the active employee population.

The rules apply to cafeteria plans generally, and specifically to HSAs offered through a cafeteria plan and health FSAs.

Under the safe harbor provisions, plans that meet certain criteria fall within a safe harbor, that is, are deemed nondiscriminatory.

Definitions
Under the new proposed rules, an HCI means an individual who is:

1) an officer;
2) a 5-percent shareholder; or
3) highly compensated (Treas. Reg. §1.125-7(a)(3)(i)).

Spouses and dependents of HCIs also are HCIs (Treas. Reg. §1.125-7(a)(3)(ii)).

A highly compensated participant (HCP) means an HCI who is eligible to participate in a cafeteria plan (Treas. Reg. §1.125-7(a)(4)).

An "officer" for the nondiscrimination test means an individual or participant who for the preceding year was an officer. Status as an officer depends on the source of the individual's authority, the term of his or her election or appointment, and the nature and extent of duties. Generally, the term "officer" means an administrative executive who is in regular and continued service. The officer title without authority is not an "officer" for the rules' nondiscrimination purposes (Treas. Reg. §1.125-7(a)(7)).

A "key employee" is defined as under pension provisions (Code Section 416) as an employee who is an:

1) officer with compensation above a defined threshold (indexed) for the plan year as defined in the Section 415(b)(1)(A));
2) a 5-percent owner of the employer; or
3) a 1-percent owner having annual compensation from the employer of more than a threshold amount as defined in Section 416 (Treas. Reg. §1.125-7(a)(10)).

Eligibility test
Cafeteria plans cannot discriminate as to eligibility in favor of HCIs. The proposed cafeteria plan rules incorporate the pension plan safe-harbor percentage test for eligibility from Treas. Reg. §1.410. Under this test, a certain minimum percentage of nonhighly compensated individuals must be benefiting under the plan relative to a certain percentage of HCIs (Treas. Reg. §1.125-7(b)).

If enough rank-and-file employees benefit relative to the number of HCIs benefiting, the plan falls within what is called a safe harbor - or a zone of ratios automatically deemed not to discriminate (Treas. Reg. §1.125-7(b)).

If the ratio of rank-and-file employees benefiting in the cafeteria plan relative to the HCIs is too low, then the plan is deemed discriminatory. However, a plan that fails the ratios test may yet qualify under another part of the test referred to as the facts-and-circumstances test (Treas. Reg. §1.125-7(b)). For example, there may be a legitimate business reason for discriminatory eligibility, such as rank-and-file employees residing outside an HMO service area who thus do not qualify for plan coverage.

Contributions and benefits test
Under another test, a cafeteria plan cannot discriminate in favor of HCPs regarding contributions and benefits (Treas. Reg. §1.125-7(c)(1)). A plan must give each similarly situated participant a uniform chance to elect qualified benefits, and the HCPs must not in disproportionate numbers actually elect those benefits (Treas. Reg. §1.125-7(c)(2)).

Under the benefits test, disproportionate election exists if the aggregate qualified benefits that HCPs elect, measured as a percentage of their aggregate compensation, exceeds the aggregate qualified benefits that nonhighly compensated participants elect, measured as a percentage of their aggregate compensation (Treas. Reg. §1.125-7(c)(2)).

> **Example.** Contel's cafeteria plan meets eligibility requirements. HCPs in the plan elect aggregate qualified benefits equaling 5 percent of aggregate compensation; nonhighly compensated participants elect aggregate qualified benefits equaling 10 percent of aggregate compensation. Contel's cafeteria plan passes the contributions and benefits test.

Key employees test

There also is a key employees test. If nontaxable benefits provided to key employees exceed 25 percent of the aggregate nontaxable benefit provided for all employees through the cafeteria plan, each key employee includes in gross income an amount equaling the maximum taxable benefits that he or she could have elected for the plan year (Treas. Reg. §1.125-7(d)(1)).

However, there is a safe harbor for POPs under which a POP passes the contributions and benefits test and the key employee test if it meets the safe harbor percentage test for eligibility described above (Treas. Reg. §1.125-7(f)(1)).

To illustrate the key employees test:

> **Example.** Employer Durango's cafeteria plan offers all employees an election between taxable benefits (such as cash) and qualified benefits (such as excludable health benefits) and meets the eligibility test. Durango has two key employees and four nonhighly compensated employees. Key employees each elect $2,000 of qualified benefits. Each nonhighly compensated employee also elects $2,000 of qualified benefits.

Key employees receive $4,000 of nontaxable benefits and nonhighly compensated employees receive $8,000 of nontaxable benefits, for a total of $12,000. Key employees receive 33 percent of nontaxable benefits. Because the plan provides more than 25 percent of aggregate nontaxable benefits to key employees, the plan fails the key employee concentration test (Treas. Reg. §1.125-7(d)(2)).

To illustrate the POP safe harbor:

> **Example.** Employer Fox's written POP offers one health plan and offers all employees the election to salary reduce the same amount or same percentage of the premium for self-only or family coverage. All key employees and all highly compensated employees elect salary reduction for the health plan, but only 20 percent of nonhighly compensated employees elect the health plan (Treas. Reg. §1.125-7(f)(2)(i)).

The POP satisfies the eligibility and contributions and benefits tests (Treas. Reg. §1.125-7(f)(2)(ii)).

Health plan safe harbor

In addition, there is a contributions and benefits test safe harbor for group health plans — but not dental or health FSAs. The safe harbor applies if the contribution on behalf of each participant equals 100 percent of the cost of health coverage of the majority of similarly situated HCPs, or at least equals 75 percent of the cost of health coverage of the similarly situated participant with the highest cost health coverage under the plan (Treas. Reg. §1.125-7(e)(1)).

Aggregation

Employers that sponsor more than one cafeteria plan have the option to aggregate plans for nondiscrimination testing purposes, which could provide flexibility particularly to employers in industries with high turnover or low participation rates, for example (Treas. Reg. §1.125-7(g)(2)).

Plans are required to do nondiscrimination testing annually. Tests must be done as of the last day of the plan year (Treas. Reg. §1.125-7(j)(1)).

> **Example**. Employer Hoopla has three employees and maintains a calendar year cafeteria plan. During 2009 Jay was an employee the entire year, Kay was an employee from May 1 through Aug. 31, 2009, and Lai was an employee from Jan. 1 to April 15, 2009.

Nondiscrimination testing must be done for the 2009 plan year and must be performed on Dec. 31, 2009, taking into account employees Jay, Kay and Lai's compensation in the preceding year (Treas. Reg. §1.125-7(j)(2)).

Section 125 Plan Non-discrimination Testing
Instructions and Forms

The discrimination rules described in the IRC Section 125 are applied to all benefits provided in a cafeteria plan in the aggregate.

The discrimination rules applicable to cafeteria plans are found in Section 125 of the Internal Revenue Code. Under these rules, a plan cannot discriminate in favor of highly compensated employees or participants for purposes of the Eligibility Test or discriminate in favor of highly compensated participants for purposes of the Contributions and Benefits Test. A plan also cannot discriminate in favor of key employees for purposes of the Key Employee Concentration Test. The required tests are as follows:

Eligibility Test: A plan cannot discriminate in favor of highly compensated employees (defined in #1 below) as to eligibility to participate.

Contributions and Benefits Test: A plan cannot discriminate in favor of highly compensated participants (defined in #1 below) as to contributions and benefits.

Concentration Test: Benefits to key employees (defined in #2 below) under the plan cannot exceed 25% of the aggregate benefits provided to all employees under the plan.

1. For purposes of the **Eligibility, Contributions and Benefits Tests**, who are "highly compensated employees"?

   A highly compensated employee is an employee who is:
   - An officer;
   - A shareholder owning more than 5% of the voting power or value of all classes of stock of the employer;
   - Highly compensated [*interpreted to mean a "highly compensated employee" as defined in Code section 414(q)]. For 2013, it includes any employee earning over $120,000 in 2017*; or
   - A spouse or dependent of one of the above.

2. For purpose of the **Concentration Test**, who is a "key employee"?

   A key employee is an employee who is:
   - An officer with annual compensation more than $175,000 (for 2017), as indexed;
   - A more than 5% owner; or
   - A more than 1% owner with compensation over $150,000, not indexed.

What nondiscrimination rules apply to Premium Only Plans?
A Premium Only Plan that pays medical premiums on a pre-tax basis is governed by Section 106 of the Code, which does not provide any rules regarding nondiscrimination. Thus, the rules above under Item 1 will apply to Premium Only Plans for medical premiums. If all employees are eligible to have their salary reduced pre-tax to pay medical premiums, and the amount of premium does not vary (except for levels of coverage), the plan should pass the nondiscrimination tests. In addition, if a Premium Only Plan also involves the payment of group life insurance premiums, it will be subject to the nondiscrimination rules under Item 1 above.

Consequences of Test Failures

What happens if the plan discriminates in favor of either highly compensated employees or key employees?
If either the **Eligibility Test** or **Contribution and Benefits Test** fail, all highly compensated employees participating in the plan must claim the amount of benefit that they COULD have received from the plan as income on their taxes for that year. If the **Concentration Test** fails, all key employees participating in the plan must claim the amount of benefit that they COULD have received from the plan as income on their taxes for that year.
Some employees can be excluded when determining the top paid group. These include employees who:
1. Have not completed 6 months of service.
2. Normally work less than 17 ½ hours per week.

3. Normally work not more than 6 months per year.

Compensation includes taxable compensation and salary reductions under cafeteria plans, 401(k) plans, and tax sheltered annuities. Stock owned by an employee's spouse, children, grandchildren, or parents is treated as owned by the employee. (See IRC Section 318)

Excluded Employees
Section 125 provides no specific authority to exclude a group of employees. However, plan administrators have routinely "borrowed" exclusions from other code sections and applied them to cafeteria plans in general. Check the plan document for details on excluded employees.

Eligibility Discrimination
A plan will not be treated as discriminatory as to eligibility, if the plan:

1. Benefits a group of employees who qualify under a classification established by the employer and found by the IRS not to be discriminatory in favor of highly compensated employees (see IRC Section 410(b)(20(A)(I)); and
2. Meets the requirements of (a) and (b) below:
   a. No employee is required to complete more than 3 years of employment with the employer or employers maintaining the plan as a condition of participating in the plan, and the employment requirement for each employee is the same.
   b. An employee who has satisfied the employment requirement of (a) above, and who is otherwise entitled to participate in the plan, commences participation no later than the first day of the first plan year beginning after the date the employment requirement was satisfied unless the employee was separated from service before the first day of that plan year.

Contributions and Benefits
A plan will not be discriminatory as to contributions and benefits if total benefits and nontaxable benefits do not discriminate in favor of highly compensated employees. Generally this determination will be made on the basis of facts and circumstances.

Section 125(c) provides a safe harbor. It provides that a cafeteria plan does not discriminate as to contributions and benefits if the qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants. The regulations under Reg. Section 1.125-1 Q & A 19 states that: "a plan must satisfy section 125(c) with respect to both benefit availability and benefit selection. Thus, a plan must give each participant an equal opportunity to select nontaxable benefits, and the actual selection of nontaxable benefits under the plan must not be discriminatory, i.e., highly compensated participants do not disproportionately select nontaxable benefits while other participants select taxable benefits."

The regulations merely provide that the utilization non disproportionately favor highly compensated participants. Unfortunately, there is no guidance as to what this means.

For example, suppose an employer allows salary redirections to a cafeteria plan to pay for dependent coverage for health insurance. All highly compensated eligible employees (100%) elect coverage. Does this satisfy IRC Section 125(c)? Presumably this plan disproportionately favors highly compensated participants.

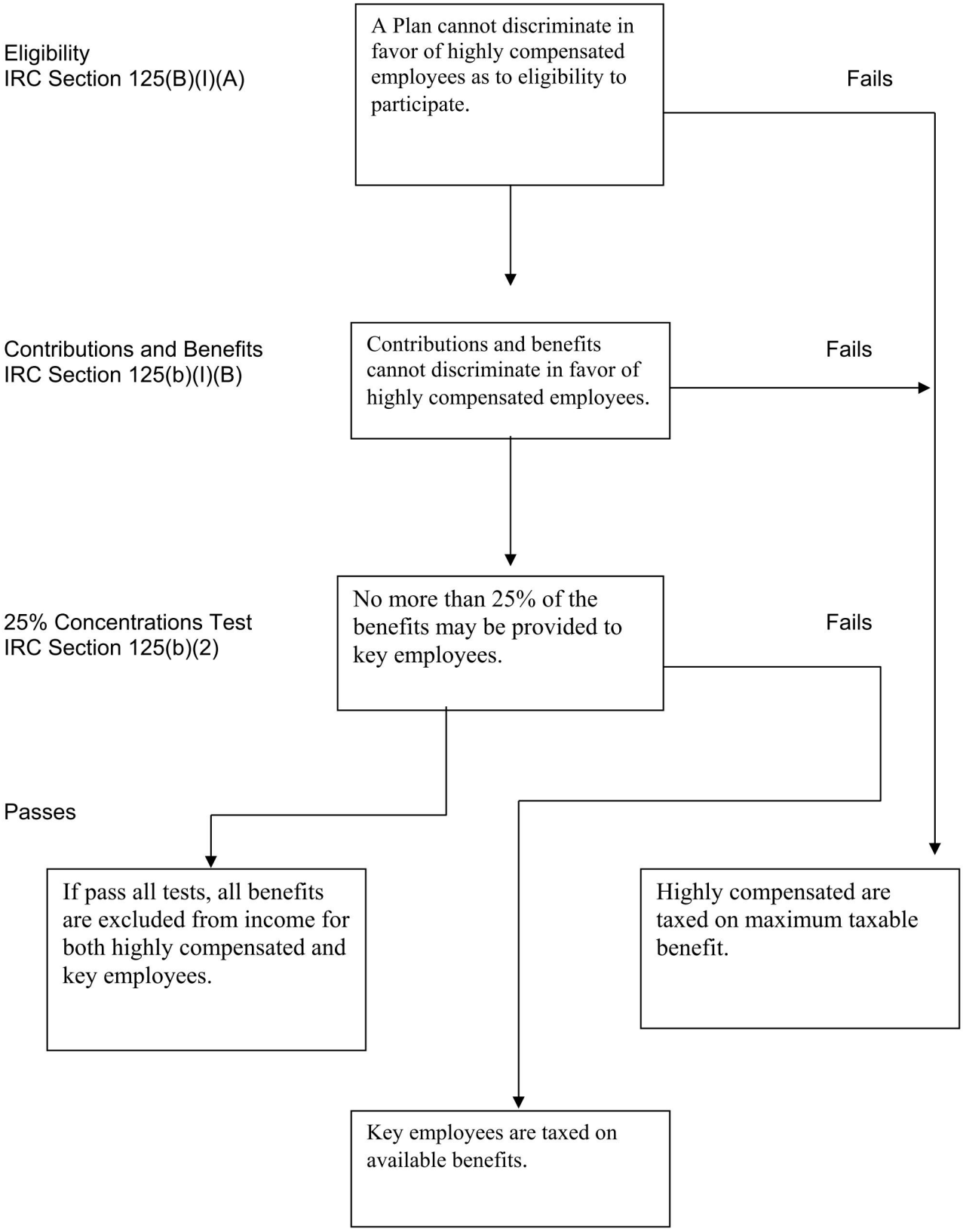

Table I

Safe/Unsafe Harbor Table

Non-highly Compensated Employee Concentration Percentage	Safe Harbor Percentage	Unsafe Harbor Percentage
0-60%	50.00%	40.00%
61	49.25%	39.25%
62	48.50%	38.50%
63	47.75%	37.75%
64	47.00%	37.00%
65	46.25%	36.25%
66	45.50%	35.50%
67	44.75%	34.75%
68	44.00%	34.00%
69	43.25%	33.25%
70	42.50%	32.50%
71	41.75%	31.75%
72	41.00%	31.00%
73	40.25%	30.25%
74	39.50%	29.50%
75	38.75%	28.75%
76	38.00%	28.00%
77	37.25%	27.25%
78	36.50%	26.50%
79	35.75%	25.75%
80	35.00%	25.00%
81	34.25%	24.25%
82	33.50%	23.50%
83	32.75%	22.75%
84	32.00%	22.00%
85	31.25%	21.25%
86	30.50%	20.50%
87	29.75%	20.00%
88	29.00%	20.00%
89	28.25%	20.00%
90	27.50%	20.00%
91	26.75%	20.00%
92	26.00%	20.00%
93	25.25%	20.00%
94	24.50%	20.00%
95	23.75%	20.00%
96	23.00%	20.00%
97	22.25%	20.00%
98	21.50%	20.00%
99	20.75%	20.00%

Eligibility Classification Test

(All Plans) Reg. Section 410(b)

_____

(Company Name)

Plan Year Ended _____

		Total Employees	Highly Compensated	Non-highly Compensated
1.	Total employees	_____	_____	_____
2.	Employees ineligible under the plan	_____	_____	_____
3.	Total eligible employees (Subtract line 2 from line 1)	_____ (A)	_____	_____(B)
4.	Total employees excluded from benefiting	_____	_____	_____
5.	Total employees eligible to benefit (Subtract line 4 from line 3)	_____	_____	_____(C)
6.	Concentration of non-highly compensated employees (Divide Non-highly compensated (B) by Total Employees (A))			_____%
7.	Safe Harbor percentage			_____%
8.	Unsafe Harbor percentage			_____%
9.	Percentage of non-excluded, non-highly compensated employees eligible to benefit under the plan. (Divide Non-highly Compensated (C) by Non-highly Compensated (B))			_____%

Conclusion:

If line 9 is less than line 7, then it fails the Nondiscriminatory Classification Test.

IRC Section 125 — Cafeteria Plan

Highly Compensated Employees (HCE) — IRC 125(e) (All Plans)

This Form Just Helps You Identify and Document HCEs

_____
(Company Name)

Plan Year Ended_____

This page simply helps you identify and list Highly Compensated Employees in your group.

List all employees who fit into one or more of the following categories. An employee may be classified as highly compensated on the basis of more than one category. When listing highly compensated employees, list each employee only once.

1. List all employees at any time during the **current plan year** with more than 5% ownership.

_____ _____

_____ _____

_____ _____

2. List all employees who, during the **current plan year**, were officers.

_____ _____

_____ _____

_____ _____

3. List all employees who are a spouse or dependent (within the meaning of IRC Section 152) of any individual listed in 1 or 2 above.

_____ _____

_____ _____

_____ _____

4. List all employees who are highly compensated within the meaning of IRC Section 414(q) $130,000 in 2021 indexed annually.

_____ _____

_____ _____

_____ _____

IRC Section 125 — Cafeteria Plan

Key Employees — IRC 416(i)(1)(A) - (All Plans)

This Form Simply Helps You Identify and Document Key Employees

_____
(Company Name)

Plan Year Ended_____

This page simply helps you identify and list all the key employees in your group.

List all employees who, at any time during the current plan year or for any of the 4 preceding plan years, fit into one or more of the following 4 categories. An employee may be classified as a key employee on the basis of more than one category. When listing key employees, list each employee only once.

1. Any officer with annual compensation more than $185,000 (for 2021), as indexed:

_____ _____
_____ _____
_____ _____
_____ _____

2. Employees with more than 5% ownership:

_____ _____
_____ _____
_____ _____
_____ _____

3. Employees with more than 1% ownership and annual compensation greater than $150,000:

_____ _____
_____ _____
_____ _____
_____ _____

Concentration Test

IRC Section 125 — Cafeteria Plan

25% Concentration IRC 125(b)(2) (All Plans)

_____
(Company Name)

Plan Year Ended_____

Total nontaxable benefits paid to all participants who are key employees _____(A)

Total nontaxable benefits paid to all other participants _____

Total nontaxable benefits paid _____(B)

Percent of nontaxable benefits paid to participants who are key employees (A / B) _____(C)

Conclusion:

If (C) is greater than 25%, participants who are key employees will include in income any "nontaxable benefits" received for the plan year.

IRC SECTION 105 (h)

(Health FSA) Medical Expense Reimbursement Plans Percentage Test

A plan is not discriminatory as to eligibility if it satisfies one of the following percentage tests.

The medical expense reimbursement plan benefits:

A. 70% or more of all employees.

or

B. 80% or more of all the employees who are eligible to benefit under the plan if 70% or more of all employees are eligible to benefit under the plan.

1. Total employees _____

2. Total ineligible (employees that do not meet eligibility requirements) _____

3. Employees eligible under the plan (subtract (2) from (1)) _____

4. Employees excluded from benefiting (i.e., S Corp. owner, seasonal/temporary EEs, EEs that have waived participation) _____

5. Employees eligible to benefit (subtract (4) from (3)) _____

6. Number of employees participating in plan _____

7. Percent of eligible nonexcluded employees who participate (divide (6 by (3)). If ≥ 70% *stop*. Do not complete the remainder of this form. _____

Complete (8) only if (7) is less than 70% and complete (9) only if (8) is 70% or more:

8. Percent of nonexcluded employees who are eligible to participate (divide (5) by (3)) _____

9. Percent of eligible employees who are participating (divide (6) by (5)) _____

Conclusion:

If line (7) is ≥ 70%, the plan has satisfied requirement A above.
If line (8) is ≥ 70% **and** line (9) is 80% or more, the plan has satisfied requirement B above.

IRC Section 129 —

Dependent Care Assistance Plan

55% Average Benefits Test IRC 129(d)(8)

(Applies to plan years beginning after December 31, 1989)

_____
(Company Name)

Plan Year Ended_____

A plan meets the requirements if the average benefits provided to employees who are not highly compensated employees under all plans of the employer is at least 55 percent of the average benefits provided to highly compensated employees under all plans of the employer.

STEP 1

Nontaxable benefits paid to highly compensated employees _____(A)

Number of highly compensated employees _____(B)

Average benefits paid to highly compensated employees (A/B) _____(C)

STEP 2

Nontaxable benefits paid to nonhighly compensated employees _____(D)

Number of nonhighly compensated employees _____ (E)

Average benefits paid to nonhighly compensated employees (D/E) _____ (F)

STEP 3

Average benefits paid to highly compensated employees (A/B) _____(C)

Ratio (currently 55%) X _____55%___

Average benefit threshold* for nonhighly compensated employee (C X 55%) _____(G)

* The threshold simply means the amount (55%) of HCE benefits that non-HCE must have for the Plan to be nondiscriminatory. Example: If the HCE average deduction is $400 a month ($400 X 55% = $220) then the non-HCE average should be at least $220 or 55% of HCE benefits to be nondiscriminatory.

Conclusion:

If (F) is less than (G), then all amounts paid to the highly compensated employees under IRC Section 129 are taxable.

NOTE: When applying this test, in the case of any benefits provided through a salary redirection agreement, the employer may disregard all employees whose compensation falls below any specified amount that is less than $25,000, all employees who have not attained age 21 and completed 1 year of service, and employees covered by a collective bargaining agreement.

CAUTION: Some people have interpreted this test to include all eligible employees in the denominator. Others believe that only employees electing dependent care assistance are to be included in the denominator. The IRS has not issued any regulations regarding the exact method of computing the Average Benefits Test but seems to favor using all eligible employees.