CoreDocuments Inc.

TO: DOUBLE J TRAILERS

RE: SECTION 125 PREMIUM ONLY PLAN DOCUMENT

To follow please find the contents for your Section 125 Premium Only Plan Document notebook. We recommend that you use a one-inch ring-bound notebook with five tabs. This document has five sections. Each new section is divided by a page showing the Section/Tab number (i.e. Section 1 – Resolution, Section 2 – Plan Document, etc.).

Instructions ONLY if you did not also order a printed, mailed document:

1) We recommend that you print the Cover Page in color on cardstock.
2) We recommend that you print Index/Table of Contents on card stock or item # AVE12171.
3) Print the rest of the document on three-hole punched paper (or three-hole punch after the document is printed).
4) Place all pages from Sections 1, 2, 3, 4 and 5 in your Section 125 one-inch ring- bound notebook. Section 1, the Resolution to Adopt, should be executed by the authorized person and then placed after Tab 1.
5) Section 2 is your new Plan Document. Place all pages of the Plan Document after Tab 2. The authorized person should execute the signature page at the end of the Plan Document and have someone witness the signing. Schedules A, B, and C should be completed either by hand or download a Microsoft Word Copy of these forms at: www.CoreDocuments.com/forms.php
6) Section 3 is your Summary Plan Description with Schedules A, B and C. Schedules A, B, and C should be completed before distribution to employees. These are the same Schedules A, B and C in Section 2 and can be copied for this Section. Place all pages of the Summary Plan Description after Tab 3.
7) Section 4 is your Salary Reduction Election Form and Change Forms. Insert the forms after Tab 4 in your binder.
8) Section 5 is a complete outline of the Cafeteria Plan Regulations. Keep a blank copy of all non-discrimination testing forms. Place the Administration Guide and Non-Discrimination Testing Forms after Tab 5.

2023 | CORE 125
PREMIUM ONLY PLAN DOCUMENT

SUMMARY OF PLAN SPONSOR RESPONSIBILITIES

As the Plan Sponsor/Administrator, you will have sole responsibility to comply with all plan administration, implementation, amendments, filing, reporting, disclosure and plan compliance requirements imposed by the plan, ERISA, the Internal Revenue Code or any other applicable law, specifically including, but not limited to:

- Reviewing the sample documents (plan, summary plan description, salary redirection agreements and nondiscrimination information) with legal counsel, executing the Plan Adoption Agreement before the first day of the plan year, and distributing the summary plan description to employees on or before their enrollment date.
- Ensuring that only common law employees participate in the plan [employees of companies described in IRC Section 414 (b), (c) or (m) and listed in the plan as participating affiliates may also participate] and ensuring that the terms of its plan document are enforced.
- Conducting initial and annual enrollments, and collecting signed Salary Redirection Agreements from employees prior to their effective date of participation. (In the absence of a valid change in status, currently eligible employees should be enrolled *prior to* the plan effective date.)
- Form 5500 Annual Returns have been suspended for Premium Only Plans. However, you may be required to file a Form *5500* Annual Return for the component benefit plans offered through the Premium Only Plan *(component benefit plans would be any self-funded or partially self-funded health plans sponsored by you through ERISA, Medical Flexible Spending Accounts (FSA) with more than 100 employees are still required to file a Form 5500).*
- Performing nondiscrimination testing required by the Internal Revenue Code (including, but not limited to: ensuring that a nondiscriminatory classification of employees is eligible for the plan, that contributions and benefits do not discriminate in favor of highly compensated employees, and that no more than *25%* of the total pre-tax benefits is received by officers and owners). Additional nondiscrimination testing may be required for the component benefits offered through the cafeteria plan (including insurance and flexible spending account benefits). You will be responsible to perform nondiscrimination testing. Nondiscrimination testing should be performed shortly after enrollment and again if there is a significant change in employee participation.
- Determining whether election changes are permissible in accordance with the provisions of the plan and Internal Revenue Code requirements.
- Ensuring that benefits offered under the plan qualify for inclusion in a Section 125 Premium Only Plan.
- Retaining documentation relating to plan operations that may be requested in an IRS or Department of Labor audit of plan operations - including, but not limited to: nondiscrimination testing information, executed copies of the plan, salary redirection agreements, plan amendments, resolutions adopting the plan, and Form 5500s - for seven years after the close of each plan year.
- Employers with 20 or more employees must provide COBRA continuation of the Health FSA benefits to those employees with a positive FSA Account balance on the date of the COBRA qualifying event.

Section 125 and W-2 Reporting

Where do I report Section 125 Plan benefits on my employees' Form W-2s?

Dependent Care benefits are shown in box 10. Health Savings Account contributions are shown in box 12, code W. Contributions to a medical reimbursement account are not specifically shown. *Effective January 1, 2012, most employers are required to report the cost of employer-sponsored health coverage in box 12, code DD. Refer to IRS Notices 2010-69 and 2011-28, and to your tax professional for more details and proper reporting.*

The Federal and Social Security wages will be decreased by all pre-tax contributions. The State taxable income for most States will be the same as the Federal wage amount. The Local Wage box may not match the Federal amount. Many localities do not recognize these plans, so local tax (if any) might be on unreduced pay, before pre-tax deductions. If so, the Local box will show higher wages than the Federal/Social Security boxes.

Section 125 and State Income Tax

The states generally follow Section 125 federal law in their tax treatment of flex plan contributions. Some states, such as New Jersey, California, Alabama, and Pennsylvania, may not permit some or all pre-taxed salary reduction contributions to be exempt from state income tax. Check with your state Department of Revenue or taxing authority.

Section 125 and Local Income Tax

Some cities and municipalities impose their own income taxes on salary reduction contributions to flex plans. Please contact your accountant for specific flex plan salary reduction local taxation issues.

Section 125 and State Unemployment Tax

Currently, most states impose unemployment taxes on flex plan contributions. Please contact your accountant or tax specialist for information on whether your state unemployment taxes may be exempt on flex plan contributions.

Section 125 and Form 1099 Reporting Requirements

If you pay health care providers directly through a Medical Expense Reimbursement Plan you are required to file a Form 1099-MISC for each health care provider for whom payments exceed $600 per year. Thus, you may want to limit reimbursements to only plan participants.

Company Owners and Section 125?

Question 1: When do owners or shareholders have to be excluded from a Section 125 plan?

Answer: In all cases except for:

1. ownership of shares in a C-Corporation, and
2. ownership of 2% or less in an S-Corporation.

Put another way the partners, members of an LLC, sole proprietors, or greater than 2% shareholders of an S corporation) cannot participate in a Premium Only Plan

Question 2: When can a company owner (whose spouse is also an employee) make use of pre-tax dollars in a Section 125 Plan? The owner holds 100% of the company ownership. Assume that discrimination is not an issue.

Answer: Code §125(d)(1)(a) states that all participants in a cafeteria plan must be employees. The proposed regulations at §1.125-1 define what is meant by "employee."

> The term "employees" includes present and former employees of the employer. All employees who are treated as employed by a single employer under subsections (b), (c), or (m) of section 414 are treated as employed by a single employer for purposes of section 125. The term "employees" does not, however, include self-employed individuals described in section 401(c) of the Code.

Further, it appears that persons who own more than 2 percent of the shares of an S corporation are not considered "employees." (An S corporation is a corporation that has elected to be treated as an "S" corporation for income tax purposes, pursuant to subchapter S of the normal income tax provisions in the Code.) See Code section 1372, which states that for purposes of the "fringe benefits" portions of the Code an S corporation is treated as a partnership and a more than 2 percent shareholder of the S corporation is treated as a partner of such partnership.

Remember to apply the "attribution" rules of Code section 318. The spouse of a 100% owner of an S corporation, or the spouse of an LLC (Limited Liability Company) owner, or a sole proprietorship, who is not employed by the company, would be considered to be the 100% owner as well. In this question, therefore, neither the company owner nor the owner's spouse could participate in the cafeteria plan.

If the corporation is a C corporation for federal income tax purposes, nothing prevents the 100% owner of the corporation's shares from participating. He or she could be an employee and therefore eligible for participation. The spouse of the 100% owner also would be eligible for participation even though attribution would apply to a C corporation owner's spouse.

A sole proprietor who employs his or her spouse (as a bona fide employee!) may not participate in a Section 125 plan, but the spouse may participate. This is because there are no shares to attribute in a sole proprietorship.

Incidentally, this method also applies to family health insurance coverage. The non-owning spouse could elect family coverage (covering, as a dependent, the spouse with 100% ownership of the company.) The health insurance premium would be completely deductible.

SECTION 1

RESOLUTION TO ADOPT

PLACE THIS PAGE AFTER TAB 1

SECTION 1 SHOULD CONSIST OF

THE FOLLOWING RESOLUTION TO ADOPT

DOUBLE J TRAILERS

RESOLUTION

IRC SECTION 125 PREMIUM ONLY PLAN

WHEREAS, Double J Trailers has determined that it would be in the best interests of its employees to adopt a "Section 125 Premium Only Plan" allowing for pre-taxed medical benefit coverage, so-called; be it known that a vote was taken, and all were in favor.

RESOLVED, that Double J Trailers adopt a so-called "Section 125 Premium Only Plan," all in accordance with the specifications annexed hereto; and, be it known that the "Double J Trailers Premium Only Plan" Document was executed October 1, 2023.

RESOLVED FURTHER, that the Company undertake all actions necessary to implement and administer said plan.

IN WITNESS WHEREOF, I have executed my name for the above named Company on October 1, 2023.

ATTEST:

Witness

By: Wayne Berry

Wayne Berry

SECTION 2

SECTION 125 PLAN DOCUMENT

PLACE ALL PAGES OF THE PLAN DOCUMENT AFTER TAB 2

AUTHORIZED SIGNER SHOULD EXECUTE THE SIGNATURE PAGE
AT THE END OF THE PLAN DOCUMENT

DOUBLE J TRAILERS

PREMIUM ONLY PLAN

PURPOSE

The Double J Trailers Premium Only Plan (the "Plan") is adopted by Double J Trailers effective October 1, 2023. The purpose of the Plan is to allow Employees of Double J Trailers and other Participating Employers, to choose between at least one permitted taxable benefit, such as cash compensation from existing income and at least one qualified benefit such as health care coverage under medical plan(s) sponsored by the Company.

Double J Trailers intends that the Plan qualify as a "cafeteria plan" under section 125 of the Internal Revenue Code of 1986 ("Code") as amended, and that the Medical Insurance Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for federal income tax purposes.

Although this Plan has been reduced to writing in order to comply with section 125 of the Code, the Plan shall also serve as an amendment to each of the health plans described in Schedule A affected by its provisions in order to permit the benefits of this Plan to be fully implemented.

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Section

Section 1

DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"Adoption Agreement" means the written agreement by which an Affiliated Company adopts this Plan.

"Affiliated Company" means:

A. any company which is a member of a controlled group of corporations with the Employer within the meaning of section 1563(a) of the Code, determined without regard to sections 1563(a) (4) and (e) (3) (C);
B. all organizations under common control with the Employer within the meaning of section 414 (c) of the Code:
C. all organizations which are included with the Employer in an affiliated service group within the meaning of section 414 (m) of the Code; or
D. any other entity required to be aggregated with the Employer pursuant to regulations under section 414 (o) of the Code.

"Beneficiary" means the person, persons or trust designated by written revocable designation filed with the Plan Administrator by the Participant to receive payments under this Plan, including the Participant and any dependents of a Participant.

"Cash" 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.

"Change in Status" has the meaning described in Section 4.3.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986 as amended, and the same as may be amended from time to time.

"Dependent" has the meaning described in Section 2.8.

"Effective Date" means October 1, 2023.

"Eligible Employee" means any non-union Employee regularly scheduled to work 30 or more hours per week for a Participating Employer.

"Employee" means an individual that the Employer classifies as a common-law employee, leased employee, or full time life insurance salesmen, and who is on the Employer's W-2 payroll, but does not include the following: (a) individuals classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Double J Trailers and any other business organization which succeeds to its business and elects to continue this Plan.

"Enrollment Period" means the calendar month preceding the beginning of any Plan Year.

"Entry Date" means the first day following completion of 90 consecutive days of active employment as an Eligible Employee.

"ERISA" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Key Employee" means any Employee defined as such in section 416(I) (l) of the Code.

"Medical Insurance Benefits" means a health care coverage option, available from time to time under the Plan, as set forth in Schedule A hereto.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2.

"Participating Employer" means Double J Trailers and any Affiliated Company that adopts this Plan with the consent of the Employer. As of the Effective Date, the Employer is the only

Participating Employer.

"Plan" means the Double J Trailers Premium Only Plan which is described herein and as amended from time to time, and which is intended to constitute a separate, written Plan for the exclusive benefit of Eligible Employees.

"Plan Number" or "PN" assigned by Double J Trailers is 501.

"Plan Sponsor" means Double J Trailers ("Employer").

"Plan Year" means the twelve-month period commencing each January 1 and ending on the subsequent December 31.

"Premium Payment Benefits" means the amount set aside for Medical Insurance Benefits under Section 3.2 and credited to the Participant's Premium Only Account.

"Premium Only Account" means the account established in each Participant's name as provided under Section 3.2 and which is used to record the allocation of Premium Payment Benefits for the expenditure of the Medical Insurance Benefits elected by a Participant.

"Premium Expense" means the expense identified with the Medical Insurance Benefits elected by a Participant in accordance with Section 3.2.

"Qualified Benefits" For purposes of section 125, Qualified Benefit means benefits excludible from an employee's 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); or employer-provided accident and health plans. A cafeteria plan may also offer long-term and short-term disability coverage as a qualified benefit (see section 106). See paragraph (q) in Sec. 1.125-1 for nonqualified benefits.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Salary Reduction Agreement" means a voluntary agreement whereby an Employee agrees to reduce his compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year) for purposes of obtaining the Medical Insurance Benefits offered by the Plan.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

Section 2

PARTICIPATION IN THE PLAN

2.1 Eligibility to Participate. Each Eligible Employee may elect to participate in the Plan if the Individual satisfies all of the following: (a) is an Employee of a Participating Employer; (b) is working 30 or more hours per week; and (c) has been employed by the Employer for 90 consecutive days. Eligibility shall also be subject to the additional requirements, if any, specified in the Medical Insurance Plan.

Self-employed individuals are not eligible to participate in the Plan. New proposed regulations make clear that:

- sole proprietors,
- partners,
- directors of corporations, and
- 2-percent shareholders of an S corporation

are not employees for purposes of this Plan. (C Corporation owners who are employees and a director of the Corporation are eligible to participate in the Plan in their capacity as an Employee).

2.2 Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Salary Reduction Agreement under which the Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if such Salary Reduction Agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year). The Salary Reduction Agreement shall be governed by Section 3 hereof. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

An Eligible Employee's spouse or dependents can only receive benefits through the Plan if they are named on an Eligible Employee's qualifying policy. Eligible Employee's spouse or dependents can not participate in the Plan independently.

2.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:

A. the date on which the Plan terminates;
B. the date on which he ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for periods on the terms and subject to the restrictions described in Section 6.4;

C. the first day of any Plan Year for which he has elected not to participate in the Plan;

D. the date on which he revokes his election and elects not to participate in Medical Insurance Benefits, on account of and consistent with a change in family status in accordance with Section 4.3; or

E. the date on which he fails to make a contribution in accordance with Section 3.5.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

Notwithstanding the foregoing, a former Eligible Employee who is absent by reason of sickness, disability, or other authorized leave of absence may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

2.4 Recommencement of Participation. If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.2. Notwithstanding the above, an election to participate in the Premium Payment Module will be reinstated only to the extent that coverage under the Medical Insurance Plan (here, major medical insurance) is reinstated. If an Employee becomes ineligible for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 2.1 before again becoming eligible to participate in the Plan.

2.5 FMLA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical Insurance Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Medical Insurance Benefit coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are

required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Medical Insurance Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Medical Insurance Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Medical Insurance Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Medical Insurance Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return

from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

2.6 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.4(d) will apply.

2.7 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator, in a manner similar to Section 2.5 (regarding the payment of contributions with respect to FMLA Leave). A Participant whose coverage under the group health insurance plan is terminated on account of his or her being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service."

2.8 Definition of Dependent. Any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) a dependent means any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) a dependent means any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year), is treated as a dependent of both parents.

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

The following qualifying criteria now apply to be a "dependent child":

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

In addition, the following qualifying criteria apply to be a "dependent relative":

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does not 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 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. This coverage is provided to such adult child (as defined in Code § 152(f)(1)) regardless of whether the child satisfies the other requirements listed above. The Notice provides important guidance and further clarifications with regard to these issues.

Section 3

BENEFITS AND METHODS OF FUNDING

3.1 Benefits Offered. When first eligible or during the Open Enrollment Period as described under Section 2.2, Participants will be given the opportunity to elect Premium Payment Benefits, as described in Section 6. See Schedule A for a complete description of available benefits and refer to specific insurance premium rate sheets for individual maximum elective contribution.

3.2 Premium Payment Benefits. Upon proper election by a Participant in accordance with Section 3.3 herein, there shall be credited to each Participant's Premium Only Account any Premium Payment Benefits that correspond to the Participant's Salary Reduction Agreement determined in accordance with Section 3.3 hereof. Such Premium Payment Benefits shall not exceed the Premium Expense of the Medical Insurance Benefits elected, set forth in Schedule A attached hereto, as it may be revised by the Employer from time to time. The Participant's Premium Payment Benefits shall be credited as and when such sum is redirected from the Participant's compensation pursuant to the Salary Reduction Agreement then in effect. The Premium Payment Benefits shall be used to pay all or part of the Premium Expense of the Medical Insurance Benefits that the Participant has designated pursuant to Section 3.3. The Premium Expense paid on behalf of any Participant shall be a charge to the balance of his Premium Only Account. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

3.3 Election of Benefits. An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits after eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the date in which participation will commence.

Each Eligible Employee shall submit to the Employer, before the close of the Enrollment Period for each Plan Year, or when Employee first becomes eligible, a Salary Reduction Form identifying the Medical Insurance Benefits to be provided by the Employer to or on behalf of the Eligible Employee. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 4.4.

Each election under this Section 3.3 may be modified by the Employer to the extent required to enable the Plan, and payments hereunder, to satisfy the requirements of Section 125 of the Code. If

an Eligible Employee separates from service with a Participating Employer during a period in which he is covered under Medical Insurance Benefits, the Employer may terminate the remaining portion of Medical Insurance Benefits coverage provided by the Plan. Any Participant or newly Eligible Employee who fails to execute an appropriate Salary Reduction Agreement during the Enrollment Period shall be deemed to have elected cash compensation (regular income) to the extent permissible.

3.4 Provision of Benefits. The Participating Employer shall provide the Medical Insurance Benefits the Participant has elected under the Plan. Eligibility for Premium Payment Benefits shall be subject to the additional requirements specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Medical Insurance Plan. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

3.5 Employer and Employee Contributions.

Employer Contributions. For Employees who elect Premium Payment Benefits, the Employer will contribute a portion of the Contributions (if applicable) as provided in the open enrollment materials furnished to Employees and/or on Election Form/Salary Reduction Agreement.

Employee Contributions. Employees who elect any of the Premium Payment Benefits, may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement, or may pay with after-tax deductions.

If a Participant does not have sufficient Premium Payment Benefits to pay for the Medical Insurance Benefits elected, the Participating Employer is authorized to withhold the additional amounts from a Participant's pay on an after-tax basis to the extent required for said Medical Insurance Benefits.

Participants are required to increase or decrease their payments under the terms of the Plan and as required by the Plan Administrator, if there is an increase or decrease in the premium payments required by an independent, third party provider in order to maintain any Medical Insurance Benefits.

Notwithstanding the foregoing, Medical Insurance Benefits shall cease to be provided to a Participant if said Participant fails to make a contribution required under the terms of the Plan.

3.6 Nondiscrimination. Contributions and benefits under the Plan shall not discriminate in favor of Highly Compensated Employees; nor shall the aggregate cost of the Medical Insurance Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Medical Insurance Benefits provided to all Employees under the Plan. The Employer may limit or deny any

Employee's Salary Reduction Agreement to the extent necessary to avoid any such discrimination.

3.7 Insurance Contracts. Any dividends or retroactive rates or other refunds which may become payable under any Medical Insurance Benefits due to actuarial error in rate calculation shall be the exclusive property of and shall be retained by a Participating Employer.

3.8 Using Salary Reductions to Make Contributions. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits and for the purposes of this Plan and the Code, are considered to be Employer contributions. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

3.9 Funding the Plan. All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Section 4

IRREVOCABILITY OF ELECTIONS AND EXCEPTIONS

4.1 Irrevocability of Elections. Except as described in this Article 4, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

4.2 Procedure for Making New Elections if Exception to Irrevocability Applies.

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 2.1 or during the Open Enrollment Period under Section 2.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.4(d) through 4.4(i), within 30 days after the events described in such Sections, or within 60 days for loss of Medicaid or CHIP coverage or notice of eligibility for a Premium Assistance Subsidy). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 4.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

4.3 Change in Status Defined. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable Module. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.4 Events Permitting Exceptions to Irrevocability Rule for All Benefits. A Participant may change an election as described below upon the occurrence of the stated events for the applicable Module of this Plan:

(a) *Open Enrollment Period* - A Participant may change an election during the Open Enrollment Period in accordance with Section 2.2.

(b) *Termination of Employment* - A Participant's election will terminate under the Plan upon

termination of employment in accordance with Sections 2.3 and 2.4, as applicable.

(c) *Leaves of Absence* - A Participant may change an election under the Plan upon FMLA leave in accordance with Section 2.5 and upon non-FMLA leave in accordance with Section 2.6.

(d) *Change in Status* - A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 2.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a

result of divorce, annulment, or legal separation).

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, to include becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights* - If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or
- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment

attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

- a Participant or their Dependent becomes eligible for a Premium Assistance Subsidy (60 day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).
- a Participant or their Dependent loses Medicaid or CHIP coverage (60 day special enrollment period provided by CHIP Reauthorization Act effective April 1, 2009).

(f) *Certain Judgments, Decrees and Orders* - If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid* - If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid, but coverage for the unaffected Participants may not be canceled or reduced. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) *Change in Cost* - For purposes of this Section 4.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are

considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Medical Insurance Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); and (b) Employees who are otherwise eligible under Section 2.1 may elect the Benefit Package Option that has decreased in cost (such as

the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(i) *Change in Coverage* - The definition of "similar coverage" under Section 4.4(h) applies also to this Section 4.4(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Medical Insurance Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) *Significant Curtailment With a Loss of Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Medical Insurance Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either

prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 4.4(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 2.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively

change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s). Beginning April 1, 2009, employees and dependents are permitted to enroll in the Employer's group health insurance plan within 60 days of the loss of Medicaid or CHIP coverage.

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the 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 that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

A Participant entitled to change an election as described in this Section 4.4 must do so in accordance with the procedures described in Section 4.2.

4.5 Election Modifications For HSA Benefits May Be Changed Prospectively at Any Time

As set forth in Section 7.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time 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 except as otherwise described in this Section 4. A Participant entitled to change an election as described in this

Section 4.5 must do so in accordance with the procedures described in Section 4.2.

4.6 Election Modifications Required by Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 5

PLAN ADMINISTRATOR

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

5.2 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

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

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

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

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

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

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

consultants;

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

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

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

5.3 Reliance on Participant, Tables, etc. The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

5.4 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

5.5 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

5.6 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

5.7 Bonding. The Plan Administrator shall be bonded to the extent required by ERISA.

5.8 Insurance Contracts. The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such

amounts are less than aggregate Employer contributions toward such insurance.

5.9 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

5.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

Section 6

PREMIUM ONLY PLAN MODULE

6.1 Benefits. The only Medical Insurance Benefits that are offered under the Premium Payment Module are benefits under the Medical Insurance Plan providing major medical benefits and other ancillary benefits outlined in Schedule A. Notwithstanding any other provision in this Plan, the Medical Insurance Benefits outlined in Schedule A are subject to the terms and conditions of the Medical Insurance Plans, and no changes can be made with respect to such Medical Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Module by electing to pay for his or her share of the Contributions for Medical Insurance Benefits on a pre-tax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Module and to pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Section 4), such election is irrevocable for the duration of the Period of Coverage to which it relates. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

6.2 Contributions for Cost of Coverage. The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Medical Insurance Benefits Provided Under the Medical Insurance Plan. Medical Insurance Benefits will be provided by the Medical Insurance Plan(s), not this Plan. The types and amounts of Medical Insurance Benefits, the requirements for participating in the Medical Insurance Plan, and the other terms and conditions of coverage and benefits of the Medical Insurance Plans are set forth in the Medical Insurance Plans. All claims to receive benefits under the Medical Insurance Plans shall be subject to and governed by the terms and conditions of the Medical Insurance Plan(s) and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits and COBRA. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Medical Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the

opportunity to continue on a self-pay basis the same coverage that he or she had under the Medical Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Medical Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Medical Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Section 7

MISCELLANEOUS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under section 125 of the Code. No amendment shall deprive any Participant or Beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their Beneficiaries, except as may be specifically authorized by statute or regulation.

7.2 Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA and Section 7.4 hereof.

7.4 Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by a Participating Employer to disburse it, whose receipt shall be a complete acquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Participating Employer.

7.5 Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Plan Administrator may require either directly to the Plan Administrator or to any person delegated by him/her.

7.6 Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be

available. Any Participant, by accepting benefits under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

7.7 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Washington to the extent not preempted by any federal law.

7.8 Source of Benefits. The Participating Employer and any insurance company contracts purchased or held by a Participating Employer shall be the sole sources of benefits under the Plan. No Employee or Beneficiary shall have any right to, or interest in, any assets of the Participating Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or Beneficiary.

7.9 No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to, purposes other than the exclusive benefit of Participants or their Beneficiaries, or for defraying reasonable expenses of administering the Plan.

7.10 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

7.11 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and Beneficiary.

7.12 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

7.13 Information to be Furnished. Participants shall provide the Employer and/or Participating Employer with such information and shall complete and sign such forms and documents, as may reasonably be requested from time to time for the Purpose of administration of the Plan.

Executed October 1, 2023

DOUBLE J TRAILERS

By:_____ Witness:_____

Eileen Reaves

DOUBLE J TRAILERS

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
Dental 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.

DOUBLE J TRAILERS

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

DOUBLE J TRAILERS

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

SECTION 3

SUMMARY PLAN DESCRIPTION (SPD)

PLACE ALL PAGES OF THE SUMMARY PLAN DESCRIPTION AFTER TAB 3

COMPLETE SCHEDULES A, B AND C AND DISTRIBUTE TO ALL EMPLOYEES

DOUBLE J TRAILERS

PREMIUM ONLY PLAN

SUMMARY PLAN DESCRIPTION

Effective Date: October 1, 2023

TABLE OF CONTENTS

As used in this Summary Plan Description (SPD), “Your” means an active Employee as described under “Who is Eligible.”

PLAN PURPOSE

The purpose of the Double J Trailers Premium Only Plan ("Plan") is to allow you to purchase coverage for health care with pretax dollars through a special type of spending account.

The advantage of this special spending account is that you pay no federal taxes on the contributions you make. This means a higher take-home pay for you than if you purchased health coverage with after-tax dollars.

The following pages explain how the Plan works.

WHO IS ELIGIBLE

If you are an employee regularly scheduled to work 30 or more hours per week for Double J Trailers ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

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) can not participate in the Plan independently.

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

WHEN YOU MAY PARTICIPATE

You are eligible to participate on the first day following your completion of 90 consecutive days of active employment as an Eligible Employee.

HOW TO ENROLL

To enroll in the Plan, you must complete an election form; thereafter, in order to participate, you must re-enroll during the calendar month period preceding each Plan Year. If you are a newly Eligible Employee and fail to complete an election form then you will be deemed to have elected cash compensation to the extent permissible (this means you have agreed to accept your pay after taxes have been taken out to pay for qualifying benefits). If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, only if your Employer permits an "evergreen election" will you be able to maintain the medical and dental benefit options, if any, that you elected for the prior year.

For the purposes of this Plan, "Plan Year" means the twelve-month period commencing January 1

and ending on the subsequent December 31. 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. However, there are certain limited situations when you can change your elections, see "Election Changes" in this Summary. 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 new Plan Year.

ELECTION CHANGES

You usually cannot change your election to participate in the Salary Reduction 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; and Changes in Coverage. 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 CHIPRA coverage; or upon becoming eligible for a Premium Assistance Subsidy. 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 and non-FMLA leave.

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.

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 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, to include becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

4. Special Enrollment Rights. 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. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of

which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents 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. 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, 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. 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. 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. 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 or CHIP.

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.

8. Change in Cost. If the cost charged to you for your Medical Insurance 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.

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.

9. Change in Coverage. You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Medical Insurance 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 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)
- *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).
- *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.

10. 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.

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

If you go on a qualifying leave under the 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 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 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, 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 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 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. 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.

ABOUT SOCIAL SECURITY 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). If your salary 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 this Plan may offset any possible reduction in Social Security benefits.

ABOUT INCOME TAXES

If you cover dependent children under medical plan(s) sponsored by Double J Trailers and your family's adjusted income is $41,646 or less, you may be eligible to receive the Supplemental Earned Income Credit for Health Insurance Premiums (based on the tax code as of January 1, 2008). However, the amount of your contributions for health coverage, which are paid on a pretax basis, would reduce the amount of this tax credit. You should, therefore, review whether it is more advantageous for you to take the full tax credit or to elect to have your medical and dental contributions paid on a pretax basis.

FUTURE OF THE PREMIUM ONLY ACCOUNT

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer 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. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

INSURANCE CONTRACTS

Any moneys refunded to the Employer or a participating Employer, due to actuarial error in the rate calculation, will be the property of and retained by the Employer or the Participating Employer. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

COBRA CONTINUATION COVERAGE

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.

REVISED DEFINITION OF "DEPENDENT" BY WFTRA

An individual is considered a "Dependent" under Section 152 of the Code and the Working Families Tax Relief Act of 2005 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:

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) 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:

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criteria does

not 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 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.

ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to help assure that all employer-sponsored group Medical Insurance Benefits conform to standards set by Congress. An employee who is a Participant in the Plan is entitled to certain rights and protections under ERISA 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, if any, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, 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 (*generally only applicable to Health FSA plans and employer sponsored self-funded health and welfare benefit plans with more than 100 participants that are required to file a Form 5500 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 a 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.

Within 180 days of receipt of a notice denying a claim you or your duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator, or by an appeals committee appointed by the Employer for that purpose (“Committee”). The Plan Administrator may extend the 180-day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate.

Under ERISA, there are steps an Employee covered under a 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 company’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 an Employee covered under this 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 loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If an Employee covered under the Plan has any questions about the Plan, the Employee should contact the Manager of Personnel of the Employer. If an Employee has any questions about this statement of the Employee’s rights under ERISA, the Employee should contact the nearest Area office of the U.S. Labor-Management Services Administration, Department of Labor.

Special Note: This is a Summary Plan Description only. Your specific rights to benefits under the Plan are governed solely, and in every respect by your Employer's Premium Only Plan document, a copy of which is available from the company 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.

ADMINISTRATIVE FACTS

Plan Sponsor and Administrator

The Plan is sponsored by Double J Trailers, 112 Whalen Loop Rd., Woodland, WA 98674. Double J Trailers also acts as Plan Administrator. The Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. The Plan Administrator has appointed the person in charge of benefits of Double J Trailers located at Double J Trailers, 112 Whalen Loop Rd., Woodland, WA 98674, to be responsible for the day-to-day operation of the Plan.

Plan Identification Numbers

The Employer Identification Number ("EIN") assigned to Employer by the Internal Revenue Service ("IRS") is 20-1937590. The Plan Number ("PN") assigned to the Premium Only Plan by the Company is 501. You should refer to these numbers in any correspondence about the Plan.

Service of Legal Process

Double J Trailers has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Company by directing the process to the Plan Administrator at the Double J Trailers address.

Classification and Funding

This Plan is classified as a Code section 125 welfare benefits plan by the Department of Labor and is funded by Employer and Employee contributions.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the Employer. The Employer'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.

DOUBLE J TRAILERS

Schedule A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

NAME OF COVERAGE

Group Health Insurance
Dental 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.

DOUBLE J TRAILERS

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

DOUBLE J TRAILERS

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

SECTION 4

FORMS

PLACE ALL PAGES OF THE FORMS AFTER TAB 4

DISTRIBUTE TO ALL EMPLOYEES WITH THE SUMMARY PLAN DESCRIPTION

Double J Trailers
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 Double J Trailers 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 government subsidized Exchange insurance premiums can only be deducted on a post-tax basis.

I hereby apply for the options listed above. If necessary, I authorize Double J Trailers 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

DOUBLE J TRAILERS
PREMIUM ONLY 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
[ ] 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*

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)*

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

6. Change in Coverage *(applies to Premium)*

[ ] 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

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.

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-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 $130,000 in 2019; 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 $185,000 (for 2019), 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.

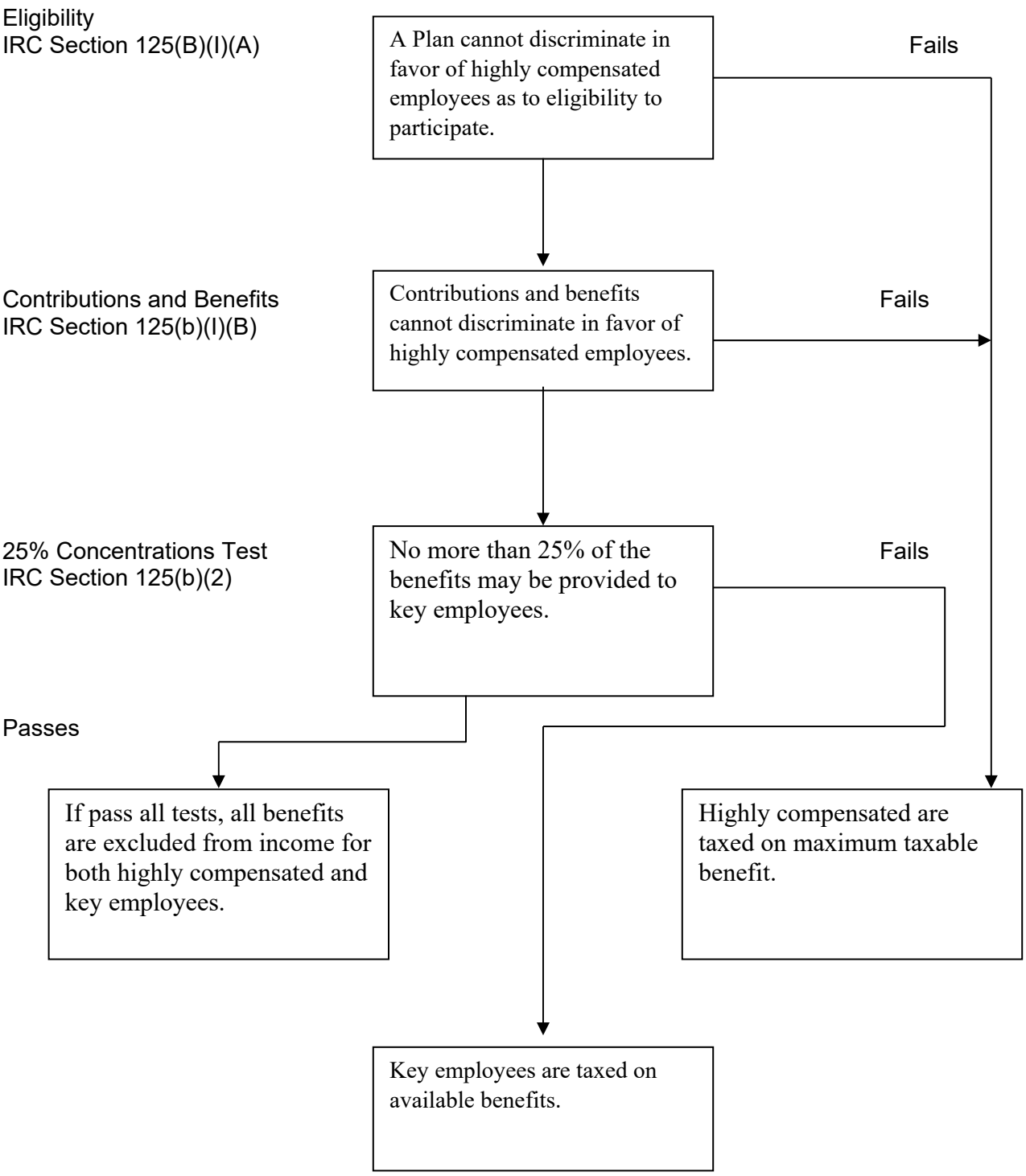

Table I

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 ($130,000 in 2021) as indexed annually within the meaning of IRC Section 414(q).

_____ _____

_____ _____

_____ _____

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 annually:

_____ _____

_____ _____

_____ _____

_____ _____

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.

