# State of Washington
# Salary Reduction Plan

Seventh Restated Effective as of August 1, 2019

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# State of Washington Salary Reduction Plan

## ARTICLE I
## PURPOSE

### Section 1.01. Preliminary Information

The state of Washington Benefits Contribution Plan was established effective January 1, 1996. The state of Washington Medical Flexible Spending Arrangement was established effective January 1, 2003. Effective January 1, 2008, these plans were merged into one plan entitled the "State of Washington Salary Reduction Plan" ("Plan"). Effective January 1, 2009, responsibility for the Dependent Care Assistance Program was transferred from the Department of Retirement Systems to the Washington State Health Care Authority (HCA). Therefore, effective January 1, 2009, the Dependent Care Assistance Program was merged into the Plan. Effective January l, 2012, the state of Washington began offering Consumer-Directed Health Plans with enrollment in Health Savings Accounts. Therefore, effective January 1, 2012, Eligible Employees may make tax-preferred contributions to Health Savings Accounts through the Plan.

The purpose of the Plan is to provide Eligible Employees with a: (i) Premium Payment Plan whereby Eligible Employees may pay their share of the monthly Health Plan premium as well as any applicable PEBB account premium surcharges on a tax-preferred basis; (ii) Medical Flexible Spending Arrangement whereby Eligible Employees may seek reimbursement of qualifying medical care expenses that are excludable from the Participant's gross income under Code Section 105(b); (iii) Dependent Care Assistance Program whereby Eligible Employees seek reimbursement of Dependent Care Expenses that are excludable from the Participants' gross income under Code Section 129; and
(iv) an opportunity to make tax-preferred contributions to Health Savings Accounts established under Code Section 223.

### Section 1.02. Effective Date

This Seventh restatement shall generally be effective August 1, 2019.

### Section 1.03. Purpose of Plan

The Plan is intended to qualify as a cafeteria plan, a premium payment plan, a "self- insured medical reimbursement plan," and a "dependent care reimbursement plan" within the meaning of Sections 105(b), 125, and 129 of the Code. To the extent permitted under the Code and any applicable state tax law, benefits elected by Participants under the Plan are excluded from their taxable income.

### Section 1.04. Governmental Plan

The Plan is a governmental plan that is exempt from the requirements of the Employee Retirement Income Security Act (ERISA) of 1974, as amended from time to time.

## ARTICLE II
## DEFINITIONS AND RULES OF INTERPRETATION

**Section 2.01. Definitions**

Whenever used throughout the Plan, the following terms shall have the following meanings when the first letter of the term is capitalized:

(a) "Annual Open Enrollment" means an annual event set aside for a period of time when Participants may make changes to their health plan enrollment and salary reduction elections for the following Plan Year including transferring from one Health Plan to another, enrolling or removing Dependents from coverage, or enrolling in or changing their election under the DCAP or the Medical FSA. They may also enroll in or opt out of the Premium Payment Plan.

(b) "Authority" means the Washington State Health Care Authority.

(c) "Code" means the Internal Revenue Code of 1986, codified at 26 U.S.C., as amended from time to time and as it applies to governmental plans.

(d) "Compensation" means, with respect to a Participant, the cash remuneration received by the Participant from an Employer that is reportable by the Employer as wages for federal income tax purposes, plus any elective deferrals or any other amounts excludable from taxable income because of an election under Code Section 125, 403(b), or 457(b); provided, however, Compensation shall not include cash remuneration received before the Participant began participation in the Plan.

(e) "Consumer-Directed Health Plan" or "CDHP" means a "high deductible health plan" as defined under Code Section 223(c)(2) which, in general, is a health plan offering a low monthly premium, a high medical deductible, and a high medical out-of-pocket limit.

(t) "Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

(g) "Continuation Coverage" means The temporary continuation of Medical FSA coverage available to participants and FSA Dependents after a qualifying event occurs as administered under ((Title XXII of the Public Health Service (PHS) Act,)) the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or PEBB insurance coverage extended by the public employee benefits board under WAC 182..: 12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

(h) "Coverage Period" means the Plan Year, except that for an individual who commences participation during a Plan Year, "Coverage Period" shall mean the portion of the Plan Year following the date on which participation commences. For an individual who terminates participation during a Plan Year, "Coverage Period" shall mean the portion of the Plan Year prior to the date participation ceases.

(i) "Dependent Care Expenses" means expenses Incurred to enable the Participant and the Participant's Spouse, if applicable, to be gainfully employed for any period during which there are one or more Qualifying Individuals with respect to the Participant, including expenses for

household services and expenses for the care of a Qualifying Individual, determined pursuant to Code Section 129 and the regulations thereunder. The term "Dependent Care Expenses" shall notinclude: (i) an expense Incurred for services outside of the household of the Participant, unless the services were Incurred for a "Type A Qualifying Individual" as defined in the Plan, or a "Type B Qualifying Individual" as defined in the Plan who regularly spends at least eight (8) hours each day in the Participant's household; (ii) an expense paid or payable to certain persons related to the Participant (within the meaning of Code Section 129(c)); nor (iii) an expense paid or payable to a dependent care center, unless the center complies with all applicable laws and governmental regulations.

(j) "Dependent Care Assistance Program" or "DCAP" means the accounting record maintained under the Plan for each electing Participant directing amounts to such an account for reimbursement of Dependent Care Expenses.

(k) "Dependent Care Reimbursement" means reimbursement for services that, if paid for by the Participant, would be considered Dependent Care Expenses.

(l) "Earned Income" means earned income as defined in Code Section 129(e)(2). If the Spouse of the Participant is a full-time student at an educational institution, or is physically or mentally incapable of caring for himself or herself and shares the Participant's principal place of abode, the Spouse shall be deemed to have Earned Income of not less than two hundred fifty dollars ($250) per month if the Participant has one Qualifying Individual, and five hundred dollars ($500) per month if the Participant has two (2) or more Qualifying Individuals.

(m) "Eligible Employee" means an Employee of a State Agency who is eligible for coverage under the Salary Reduction Plan as identified in WAC 182-12-116.

(n) "Employee" means an employee of a state agency, state community and technical college, state board for community and technical colleges, a state four-year institution of higher education, or any other entity identified by state statute or by the PEBB Program in rules promulgated in the WAC.

(o) "Employer" means the state of Washington.

(p) "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

(q) "FSA Dependent" means a Participant's Spouse and the Participant's dependent as defined in Code Section 152, determined without regard to subsections (b)(l), (b)(2), and (d)(l)(B) thereof, and any child (as defined in Section 152(±)(1)) of the Participant who as of the end of the taxable year has not attained age 27.

(r) "Grace Period" means, with respect to the Medical FSA only, the two month and fifteen day period immediately following the end of the Plan Year in which Participants may incur Qualifying Health Care Expenses that may be reimbursed from the prior Plan Year's Medical FSA election.

(s) "HCA" means the Washington State Health Care Authority.

(t) "Health Plan" means a plan offering medical coverage or dental plan coverage, or both, developed by the Public Employees Benefits Board and provided by a contracted vendor or self-insured plans administered by the HCA; however, such term shall not include coverage for qualified long-term care services as defined in Code Section 7702(B)(c) or coverage for any product which is advertised, marketed, or offered as long-term care insurance.

(u) "Health Savings Account" or "HSA" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the HSA Qualified Medical Expenses of the account beneficiary, the account beneficiary's spouse, and the account beneficiary's dependents (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(l)(B) thereof) that meets the requirements of Code Section 223(d) and that is recognized by the Plan Administrator, in its sole discretion, as eligible to receive contributions under the Plan.

(v) "Health Savings Account Trust Custodian" or "HSA Trust Custodian" means the bank, insurance company, or other person or entity that maintains and administers the trust account for Participants' HSAs.

(w) "Hearing Officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

(1) A director-designated HCA employee; or

(2) When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the OAH.

(x) "HSA Eligible Employee" means an Eligible Employee who meets all of the following criteria:

(1) He or she is a participant in a PEBB CDHP;

(2) He or she is not, while covered under a CDHP, covered under any other health plan that is not a CDHP and that provides coverage for any benefit covered under the CDHP (except as provided in Code Section 223(c)(l)(B));

(3) He or she is not claimed as a dependent on another individual's tax return; and

(4) He or she is not covered by a federal government or military health care plan (e.g., Medicare, TRICARE, etc.).

(y) "HSA Qualified Medical Expenses" means amounts paid by a Participant for medical care as defined in Code Section 213(d) for such Participant, the Participant's Spouse, and the Participant's dependents (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(l)(B) thereof), but only to the extent such amounts are not compensated for by insurance or otherwise. HSA Qualified Medical Expenses include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin. HSA Qualified Medical Expenses shall not apply to any payment for insurance premiums, except with regard to any expense for coverage under: (i) a health plan during any period of continuation coverage under federal law; (ii) a qualified long-term care insurance contract (as defined in Code Section 7702B(b)); (iii) a health plan during a period in which the individual is receiving unemployment compensation under any federal

or state law; or (iv) in the case of a Participant who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a Medicare supplemental policy (as defined in section 1882 of the Social Security Act).

(z) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(aa) "Incurs" or "Incurred" refers to the date on which the care or services that give rise to a Qualified Health Care Expense or a Dependent Care Expense are provided, not the date on which the Participant is formally billed or pays for such care or services. A Qualified Health Care Expense or a Dependent Care Expense is not treated as Incurred unless the care or services giving rise to the expenses are provided while the individual is a Participant or eligible Dependent, as applicable.

(bb) "Medical Flexible Spending Arrangement" or "Medical FSA" means the accounting record maintained under the Plan for each electing Participant directing amounts to such an account for reimbursement of Qualifying Health Care Expenses.

(cc) "Participant" means an Eligible Employee who has commened participation in the Plan in accordance with Section 3.01 and has not subsequently become ineligible to participate under Section 3.02.

(dd) "PEBB" means the Public Employees Benefits Board.

(ee) "PEBB Appeals Unit" means the Unit within the Health Care Authority that receives, processes, and in some cases issues the orders on appeals relating to the administration of the Plan. The Director of the HCA has delegated the authority to hear appeals at the Brief Adjudicative Proceeding level to presiding officers (employed within the Appeals Unit) and review officer or officers employed by the HCA. The Director has also delegated the authority to hear appeals that are adjudicated in the formal hearing process to a Hearing Officer employed by the HCA or by the Office of Administrative hearings, a separate state agency.

(ff) "PEBB Program" means the program within the HCA that administers insurance and other benefits for eligible employees (as defined in WAC 182-12-114), eligible retired and disabled employees (as defined in WAC 182-12-171 and 182-12-180), eligible survivors (as described in 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as defined in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

(gg) "PHSA" means the Public Health Services Act, as amended from time to time.

(hh) "Plan" means the state of Washington Salary Reduction Plan, as set forth in this document and as amended from time to time.

(ii) "Plan Administrator" means the HCA or the HCA's designee as provided in Section 9.01.

(jj) "Plan Year" means the 12-month period beginning on each January 1 and ending on each December 31.

(kk) "Premium Payment Plan" means a benefit Plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the Salary Reduction Plan.

(11) "Presiding Officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is a director designated HCA employee.

(mm) "Privacy Regulations" means the regulations under the standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, Subpart E, as amended from time to time).

(nn) "Protected Health Information" means "protected health information" as referenced at 45 CFR § 164.501 which, generally, means information (including demographic information) that: (i) identifies an Individual (as defined at 45 CFR§ 160.103) or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual; is created or received by a health care provider, a health plan, or a health care clearinghouse; and (iii) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future Payment (as defined at 45 CFR § 164.501) for the provision of health care to an Individual.

(oo) "Qualified Reservist Distribution" means a distribution to a Participant of all or a portion of the balance of the Participant's Medical FSA contribution if: (i) the Participant is a member of a reserve component, as defined by 37 U.S. C. § 101, ordered or called to active duty for a period of 180 days or more or for an indefinite period; and (ii) the request for distribution is made during the period beginning with the order or call to active duty and ending on the last day of the Plan Year that includes the date of the order or call to active duty. If the period specified in the order or call is less than 180 days, a Qualified Reservist Distribution is not allowed. However, a subsequent call or order that increases the total period of active duty to 180 days or more will qualify a Participant for a Qualified Reservist Distribution.

(pp) "Qualifying Health Care Expense" means any medical expense Incurred by a Participant or his or her FSA Dependents for medical care (as defined in Code Section 213(d), but excluding qualified long-term care services as defined in Code Section 7702B(c) or coverage for any product which is advertised, marketed, or offered as long-term care insurance). The term includes insulin (regardless of whether it is dispensed through a prescription), but excludes any other medicine or drug that is not prescribed (within the meaning of Code Section 213(b)). "Qualifying Health Care Expense" also does not include any premium paid for insurance for medical care. An expense is a Qualifying Health Care Expense only to the extent that the Participant, or his or her FSA Dependents, are not otherwise reimbursed or entitled to reimbursement for the expense through insurance or otherwise, and to the extent that the Participant or his or her FSA Dependents are legally obligated to pay for the expense.

(qq) "Qualifying Individual" means a dependent (within the meaning of Code Section 152(a)(l)) of the Participant who is under age thirteen (13) ("Type A Qualifying Individual"), or a dependent (as defined in Code Section 152, determined without regard to subsections (b)(l), (b)(2), and (d)(l)(B)) or Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who shares the Participant's principal place of abode (which shall not be in violation of local law) for more than one-half of the year ("Type" B Qualifying Individual"). A child

of divorced or separated parents is treated as a Qualifying Individual of only the custodial parent if: (i) the child is in the custody of one or both parents for more than one-half of the calendar year; (ii) the child receives over one-half of the child's support during the calendar year from the child's parents; and (iii) the parents are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a separation agreement, or have lived apart at all times during the last six (6) months of the calendar year.

(rr) "RCW" means the Revised Code of Washington, as amended from time to time.

(ss) "Review Officer or Officers" means one or more delegates from the director that consider appeals relating to the administration of PEBB benefits by the PEBB Program.

(tt) "Service" means the process described in WAC 182-16-058.

(uu) "Section" means, when not preceded by the term "Code," a section of the Plan.

(vv) "Security Regulations" means the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164, Subparts A and C, as amended from time to time).

(ww) "Spouse" means an individual who is married to an Eligible Employee if the marriage would be recognized by any state, possession, or territory of the United States. For purposes of the DCAP, an individual will not be considered to be the Spouse of an Eligible Employee if: (i) the Eligible Employee and his or her spouse are divorced; or (ii) the Eligible Employee and his or her spouse file separate returns, the Eligible Employee maintains a household which is the principal place of abode for a child (with respect to which the Eligible Employee is entitled to a deduction) for more than one-half of the calendar year, the Eligible Employee furnishes more than one-half of the cost of maintaining that household, and the Eligible Employee's spouse was not a member of that household during the last six months of the year.

(xx) "State Agency" means an entity set forth in the definition of "state agency" in WAC 182-12-109.

(yy) "Summary Health Information" has the same definition as in 45 CPR§ 164.504(a), as amended from time to time, and means generally information that may be individually identifiable health information, and:

(1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan has provided health benefits; and

(2) From which the information described at 45 CPR § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in 45 CPR§ 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.

(zz) "Third-Party Administrator" means the entity designated by the HCA to provide claims adjudication and other services in connection with the Plan.

(aaa) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

(bbb) "WAC" means the Washington Administrative Code, as amended from time to time.

**Section 2.02. Rules of Interpretation**

In interpreting the Plan, the following rules of interpretation shall apply:

(a) The Plan shall be interpreted to be in compliance with the requirements of Code Sections 105, 106, 125, 129, and 223, and any other applicable provisions of law so that the intended tax consequences of the Plan are achieved.

(b) The Plan shall be construed, enforced, and administered, and the validity thereof determined, in accordance with applicable provisions of the Code and, to the extent not inconsistent with the Code, in accordance with the laws of the state of Washington.

(c) Any reference to a Code Section shall be deemed a reference to any comparable or succeeding provision of any legislation, law, or rule that amends, supplements, or replaces such Code Section.

(d) Words used herein in the masculine gender shall be construed to include the feminine gender, and words used in the singular or plural shall be construed as being in the plural or singular, where appropriate.

(e) Headings and subheadings are inserted for convenience and are not to be considered in the construction of any provision of the Plan.

(f) If a provision of the Plan is held illegal or invalid for any reason, that provision shall be deemed null and void, but the invalidation of that provision shall not otherwise impair or affect the Plan.

## ARTICLE III
## PARTICIPATION AND TERMINATION

**Section 3.01. Commencement of Participation**

(a) For purposes of the Premium Payment Plan, an Eligible Employee shall automatically be enrolled as a Participant upon enrollment in medical coverage in a Health Plan, unless the Eligible Employee elects to opt-out of participation pursuant to Section 4.02(b).

(b) For purposes of the Medical FSA and the DCAP, an Eligible Employee shall become a Participant under the Plan effective as of the first day of the month following the date that: (i) the individual becomes an Eligible Employee; (ii) the Eligible Employee completes a benefit election and salary reduction agreement electing the Medical FSA and/or the DCAP; and (iii) the benefit election form is received by the Eligible Employee's personnel, payroll or benefits office. However, an Eligible Employee who becomes eligible to become a Participant on the first day of a month will become a Participant on that day.

(c) For purposes of making contributions to an HSA, an Eligible Employee shall become a Participant under the Plan effective as of the first day of the month following the date that: (i) the individual becomes an Eligible Employee; (ii) the Eligible Employee enrolls in a CDHP; (iii) the Eligible Employee completes a salary reduction agreement electing to make contributions to an HSA; and (iv) the salary reduction agreement form is received by the Eligible Employee's personnel, payroll or benefits office.

**Section 3.02. Cessation of Participation**

A Participant shall cease to be a Participant as of the earliest of:

(a) The date on which the Plan terminates;

(b) The date on which the Participant ceases to be an Eligible Employee (except as otherwise required by USERRA, the FMLA, or COBRA);

(c) The last day of the month the Participant makes the required contributions under the Plan;

(d) The date on which coverage under all benefits offered under this Plan ends; or

(e) The last day of the calendar month in which an unpaid leave of absence (other than FMLA leave) begins.

Notwithstanding the provisions contained in this Section, a Participant who ceases to be a Participant in the Plan pursuant to this Section may nonetheless be entitled to continue Health Plan enrollment and participation in the Medical Flexible Spending Arrangement, as provided in the PEBB rules and COBRA, on an after-tax basis. A Participant who ceases to be a Participant during a Plan Year, or who is no longer enrolled in a CDHP, will no longer be entitled to make or receive HSA contributions through the Plan.

**Section 3.03. Section 3.03. Reinstatement of Participation by Former Participants**

A former Participant who terminates employment with the Employer shall have his or her elections reinstated for the Premium Payment Plan, Medical FSA, DCAP, and/or HSA (as applicable) under the Plan if the Participant returns to employment with the Employer within thirty (30) days or less following his or her termination of employment. If such Eligible Employee returns to employment more than thirty (30) days after such termination of employment, such individual: (i) may again be automatically enrolled in the Premium Payment Plan during the Plan Year of reemployment if such individual satisfies the requirements of Section 3.01 (a); (ii) may not reenroll in the Medical FSA or the DCAP until the Plan Year following reemployment (provided that such individual once again satisfies the requirements under Section 3.0l(b) and makes an election under the Plan for such subsequent Plan Year), and (iii) may elect to reduce his or her cash Compensation by a specified amount and direct the Employer to use the reduction amount to make contributions to the Participant's HSA pursuant to Section 4.01.

**Section 3.04. Section 3.04. Unpaid FMLA and USERRA Leaves of Absence**

(a) A Participant taking an unpaid leave of absence, which qualifies as an FMLA or USERRA leave of absence, may cease all or a portion of required contributions consistent with the requirements of the FMLA and USERRA; provided, however, such person shall be able to continue enrollment in PEBB benefits (as provided in PEBB rules), as well as coverage under the Medical FSA (as provided in Section 6.07) upon reinstatement of participation during the same Plan Year. If the Participant elects to continue coverage while the Participant is on an unpaid FMLA or USERRA leave of absence, payments shall be made only either: · (i) by prepaying. for the period of the leave; or (ii) on a pay-as-you-go basis, under PEBB's existing rules for payment by Employees on an unpaid leave, and the Participant shall be entitled to coverage on the same terms and conditions as if he or she were an active Employee. The right to cease contributions under this Section shall be in addition to a Participant's right to cease contributions under Article IV. No other new elections may be made under the Plan upon return from such leave unless otherwise consistent with the provisions of Section 3.04(b), Sections 4.04 through 4.10, or the FMLA or USERRA.

(b) With respect to the Medical Flexible Spending Arrangement, if the Participant chooses to discontinue contributions during the FMLA leave, upon his return the Participant may elect to: (i) resume participation at the coverage level elected at the start of the Coverage Period, with a corresponding increase in contributions for the balance of the Plan Year; or (ii) participate at a reduced coverage level for the year, and resume the per pay contribution in effect prior to the FMLA leave.

(c) Employer contributions to an HSA will continue while a Participant is enrolled in a CDHP while on FMLA leave.

**Section 3.05. Conditions for Receipt of Benefits**

As a condition of receiving benefits under the Plan, a Participant must:

(a) Furnish all applications, enrollment forms, and other documents reasonably required by the Plan Administrator; and

(b) Observe all Plan rules and regulations.

## ARTICLE IV
## CONTRIBUTIONS AND BENEFIT ELECTIONS

**Section 4.01. Compensation Reduction Elections**

(a) Once an Eligible Employee becomes a Participant under Section 3.0 1 (a), the Participant shall be deemed to automatically elect to become a Participant under the Premium Payment Plan under the Plan, unless the Participant elects to opt-out of the Premium Payment Plan as described in Section 4.02(b) below. A Participant who does not opt-out of the Premium Payment Plan shall have his or her cash Compensation reduced on a pre-tax basis per pay period by a specified amount, and such reduction shall be used to pay the Participant's share of the Health Plan premium as well as any applicable PEBB account premium surcharges. The Employer shall establish the Participant's PEBB account premium surcharges and share of the Health Plan premium from time to time. The Participant's cash Compensation shall be reduced by substantially equal amounts for each pay period occurring during the Plan Year. The amount of the Participant's reduction for a Plan Year shall not exceed the lesser of: (i) the Participant's Compensation; or (ii) the total maximum

contribution for the Health Plan premium and any applicable PEBB account premium surcharges for the Plan Year. A Participant's election shall be subject to the terms of this Article.

(b) In addition to, or in lieu of, an election under Sections 4.01 (a) or (c), a Participant may elect to reduce his or her cash Compensation, per payroll period, by a specified amount and direct the Employer to use the reduction amount to make contributions to the Medical FSA and/or DCAP. The reduction amount shall be applied pursuant to and shall be subject to the limitations specified in Articles VI and VII, as applicable. Such election must be filed within the applicable election period specified in Section 4.02. Medical FSA elections shall be subject to the prohibition on simultaneous enrollment in an HSA and Medical FSA as set forth in Section 8.03

(c) In addition to, or in lieu of, an election under Sections 4.01 (a) or (b), a Participant who is an HSA Eligible Employee may elect to reduce his or her cash Compensation by a specified amount and direct the Employer to use the reduction amount to make contributions to the Participant's HSA. Such election must be made in accordance with Article VIII, as applicable, including, without limitation, the prohibition on simultaneous enrollment in an HSA and a Medical FSA as set forth in Section 8.03. Participant contributions may only be made to the Participant's HSA linked with enrollment in a PEBB CDHP.

**Section 4.02. Elections and Election Period**

(a) The Plan Administrator, or its designated representative, shall provide materials regarding the Plan to each new Eligible Employee as soon as practicable after he or she becomes an Eligible Employee. Additionally, during the month of November, or such other reasonable period designated by the Employer before the beginning of each Plan Year, the Plan Administrator shall provide an Annual Open Enrollment period to all Eligible Employees. Elections made during the Annual Open Enrollment period shall be effective on the first day of January in the following Plan Year.

(b) For the initial Plan Year in which an individual becomes an Eligible Employee, in order to elect to opt-out of the automatic election under Section 4.0l(a), or to make an election under Section 4.01 (b) to participate in the Medical FSA or DCAP, the Eligible Employee must make an election within thirty-one (31) days of the date he or she becomes an Eligible Employee. An election will be effective as of the first day of the month following the date that: (i) the individual becomes an Eligible Employee; (ii) the Eligible Employee completes an opt-out form or a benefit election and salary reduction agreement electing the Medical FSA and/or the DCAP; and (iii) the benefit election form is received by the Eligible Employee's personnel, payroll or benefits office. However, an Eligible Employee who becomes eligible to become a Participant on the first day of a month will become a Participant on that day. An individual who elects to participate in the Health Plan shall also participate in the Premium Payment Plan for Health Plan premiums and any applicable PEBB account premium surcharges under this Plan unless he or she affirmatively declines such participation within thirty-one (31) days of the date he or she becomes an Eligible Employee. In the event the Health Plan option the Participant is enrolled in is discontinued and the Participant fails to elect another Health Plan option, he or she shall be enrolled in the state-administered Uniform Medical Plan Classic, or such other plan designated in writing by the Director of the HCA as the default plan.

(c) Elections for tax-preferred deductions for Health Plan premium and any applicable PEBB account premium surcharges shall continue from Plan Year to Plan Year unless a Participant

affirmatively submits the required form to change his or her election regarding the Premium Payment Plan during Annual Open Enrollment. A Participant may also change his or her election regarding the Premium Payment Plan as provided under Sections 4.04 to 4.10 (as a result of a change in status event).

(d) Prior to each Plan Year, a Participant must complete and submit the required election form to the Plan Administrator, or the Plan Administrator's designee, within the Annual Open Enrollment period designated by the Plan Administrator to make an election to participate in the Medical FSA and/or the DCAP. All required election forms must be received no later than the last day of the Annual Open Enrollment period. An election pursuant to this subsection shall be effective as of the first day of January for the following Plan Year. If the Participant fails to return a completed election form by the required deadline, the individual shall not participate in the Medical FSA or the DCAP for the following Plan Year, except as provided under subsection and Sections 4.04 to 4.10 of the Plan.

(e) To make a new election outside of the Annual Open Enrollment as a result of a change in status or an event which created a special open enrollment pursuant to Sections 4.04 through 4.10 of the Plan, a Participant's required election form must be received by the Plan Administrator, or its designated representative, by no later than sixty (60) days following the date the change in status or event that created the special open enrollment occurred. An election pursuant to this subsection shall be effective on the first day of the month following the later of: the receipt of the new election form by the Plan Administrator; or (ii) the date of the event which created a special open enrollment; provided, however, that in the event of the placement of a child for adoption, or an adoption, the effective date of the change shall be the date of placement for adoption or adoption (as applicable). In the event of the birth of a child, the change under the Premium Payment Plan shall be the first day of the month in which the child was born. A change that is effective on the first day of a month shall be effective on that day.

**Section 4.03. Cessation of Required Contributions**

Subject to Section 3.04, benefits under the Plan shall cease to be provided to a Participant if such Participant fails to make required contributions, and such individual may not make a new benefit election for the remaining portion of that Plan Year (with respect to the Medical FSA and the DCAP). Such individual may again become a Participant in the Plan in the following Plan Year, as provided pursuant to Sections 4.02(c) and 4.02(d), provided such individual is an Eligible Employee.

**Section 4.04. Special Open Enrollment for Change in Health Plan Election**

A Participant may revoke his or her Health Plan election and make a new election during a special open enrollment as described in WAC 182-08-198.

**Section 4.05. Special Open Enrollment for Change in Premium Payment Plan, Medical Flexible Spending Arrangement (FSA), or Dependent Care Assistance (DCAP) Elections**

A Participant may enroll or revoke their election and elect to opt out of his or her Premium Payment Plan election. For Medical FSA election, and DCAP, a participant may enroll or revoke their election and make a new election during a special open enrollment as described in WAC 182-08-199.

**Section 4.06. Special Open Enrollment to the Waived Status of Medical Enrollment Election**

A Participant may change the waived status of his or her medical enrollment election during a special open enrollment as described in WAC.182-12-128.

**Section 4.07. Special Open Enrollment to Enroll or Remove Eligible Dependents**

A Participant may change his or her elections to enroll or remove eligible dependents during a special open enrollment as described in WAC 182-12-262.

**Section 4.08. Special Open Enrollment for Event Described in a PEBB Program Administrative Policy**

A Participant may change his or her elections to change his or her Health Plan election, Premium Payment Plan election, Medical FSA election, DCAP election, medical enrollment election, or eligible dependent enrollment elections as specifically allowed for an event described in an active PEBB Program administrative policy that creates a special open enrollment.

**Section 4.09. Changing an Attestation to a PEBB Account Premium Surcharge**

A Participant may change his or her Premium Payment Plan election consistent with a change in his or her attestation to a PEBB account premium surcharge only ·during the times described in WAC 182-08-185.

**Section 4.10. New Election Due to a Court Order**

A Participant may make changes consistent with a court order in accordance with WAC 182-12-263. Changes made pursuant to a court order will only be tax-preferred under the Plan if the change is made within the times described in WAC 182-08-198.

**Section 4.11. Irrevocability of Elections**

An election, once made, shall remain in effect until the earliest of: (i) the date on which the Eligible Employee ceases to be a Participant; (ii) the effective date of a new election pursuant to Sections 4.04 through 4.1O; (iii) the date the Plan is terminated; or (iv) the end of the Plan Year. Except as provided in Sections 4.04 through 4.10, or as otherwise required by law, a Plan Year election may be changed only during the Annual Open Enrollment with an effective date of January 1 of the following Plan Year.

**Section 4.12. Effect of Failure to File an Enrollment Form**

A Participant's failure to return a completed enrollment form per Section 4.02(b) or 4.02(d) on or before the specified due date shall constitute an election not to participate in the Medical FSA and the DCAP.

**Section 4.13. Authority of the Plan Administrator to Cancel or Revise Certain Elections**

(a) Notwithstanding any other provisions of the Plan, to the extent required by Code Section 125, the following non-discrimination rules shall apply: (i) the Plan shall not discriminate in

favor of highly compensated employees (as defined by Code Section 125(e)) as to eligibility to participate or as to contributions or benefits; and (ii) the benefits provided to key employees (as defined by Code Section 416(i)(l)) shall not exceed 25% of the aggregate benefits provided to all Participants. If the Plan Administrator determines, before or during the Plan Year, that the Plan (or any part thereof) may fail to satisfy any applicable non-discrimination requirement imposed by the Code, the Plan Administrator shall cancel or revise the elections of key employees and/or highly compensated employees to receive benefits under the Plan to the extent that the Plan Administrator determines that such cancellation or revision is necessary to satisfy the Code's non-discrimination requirements.

(b) The DCAP shall be administered to be in compliance with all applicable non-discrimination requirements of the Code. Notwithstanding any other provision of the DCAP, the Plan Administrator may limit the amounts paid or reimbursed with respect to any Participant who is a highly compensated employee within the meaning of Code Section 414(q) to the extent the Plan Administrator deems the limitation appropriate to assure compliance with respect to any applicable non-discrimination requirement.

(c) If the Participant's cost for Health Plan coverage (whether the cost of the Health Plan premium or applicable PEBB account premium surcharges) increases or decreases during the Plan Year (regardless of whether such increases or decreases result from actions taken by the Employer, a State Agency, the Health Plan, the Plan Administrator, or the Participant), then an affected Participant shall not be required to make a corresponding change in PEBB account premium surcharges or his or her share of the cost of the Health Plan premium, and the Plan may make an increase or decrease, as appropriate, in such premium payments or PEBB account premium surcharges.

(d) The Plan Administrator may cancel or revise a Participant's elections to avoid simultaneous enrollment in an HSA or a Medical FSA as set forth in Section 8.03.

(e) The Plan Administrator may cancel or revise a Participant's elections to enroll in an FSA or DCAP or to switch from one PEBB health plan to another PEBB health plan, upon the establishment, by clear and convincing evidence, of a mistake of fact by the Participant when making the election. The determination of whether a mistake of fact was made shall be in the Plan Administrator's sole discretion under the factors set forth in Exhibit A to the Plan. The Plan Administrator shall use Exhibit A in only the following instances: (i) when the election in question involves a Medical FSA, (ii) when the election in question involves DCAP, or (iii) when the election in question involves a request to switch from one PEBB health plan to another PEBB health plan because the subscriber or the subscriber's dependent is experiencing a disruption of medical care that impacts a documented on-going course of treatment. The Plan Administrator may not cancel or revise a Participant's election to enroll, not enroll, disenroll, or waive coverage for the subscriber or any of the subscriber's dependents in a PEBB health plan.

## ARTICLEV
## BENEFITS

The tax-preferred status of a Health Plan, Medical FSA, DCAP, or HSA payment or contribution under this Plan does not alter or supersede any of the benefits, participation requirements, or other terms and conditions of the Health Plan, Medical FSA, DCAP, or RSA. The maximum amount of elective contributions for each Participant are his or her share of the cost of premium under

the Health Plan and any applicable PEBB account premium surcharges, plus the maximum contribution amounts set forth for the Medical FSA, the DCAP, and the HSA.

## ARTICLE VI
## MEDICAL FLEXIBLE SPENDING ARRANGEMENT

### Section 6.01. Establishment of Medical Flexible Spending Arrangement

The Plan Administrator, or its designated representative, shall maintain a separate Medical FSA for each Coverage Period with respect to each Participant who has elected to make contributions to a Medical FSA pursuant to Article IV. The Medical FSA shall be maintained for bookkeeping purposes .only, and except as otherwise required by law, amounts credited to a Participant's Medical FSA shall remain part of the general assets of the Plan until paid pursuant to this Article. No interest or other earnings shall be credited to any Participant's Medical FSA.

### Section 6.02. Crediting of Medical Flexible Spending Arrangement

As of the beginning of the Coverage Period, there shall be credited to a Participant's Medical FSA the annualized amount by which the Participant has elected to have his or her Compensation reduced pursuant to Section 4.0l(b) for the reimbursement of Qualifying Health Care Expenses. Notwithstanding the preceding sentence, the maximum amount that may be credited to a Participant's Medical FSA for a Coverage Period shall be limited to $2650, and the minimum annual amount that must be credited to a Participant's Medical FSA shall be $240; provided, however, in the case of two Participants who are married to each other, each Participant may elect to have up to $2,650 credited to his or her Medical FSA. These dollar amounts are subject to change annually.

### Section 6.03. Debiting of Medical Flexible Spending Arrangement

As of the date of any payment under this Article to or for the Participant's benefit for Qualifying Health Care Expenses Incurred during a Coverage Period or within the Grace Period (if applicable), the Participant's Medical FSA shall be debited by the amount of the payment, subject to the annualized amount credited to the Medical FSA for the Coverage Period.

### Section 6.04. Forfeiture of Medical Flexible Spending Arrangement

Except as provided in Section 6.08, the amount credited to a Participant's Medical FSA shall be used only to reimburse the Participant for Qualifying Health Care Expenses Incurred during the Coverage Period or within the Grace Period (if applicable) while a Participant, and only if the Participant applies for reimbursement by no later than March 31 following the end of the Coverage Period and the Grace Period. · Any balance credited to a Participant's Medical FSA that remains after all reimbursements for the Coverage Period and the Grace Period have been made, shall be forfeited after March 31 following the applicable Grace Period. Such forfeited amounts shall be forwarded .to

the Authority and used to pay expenses and fees associated with the Plan, or for such other use as determined by the Plan Administrator that are consistent with Code Section 125.

**Section 6.05. Claims for Qualifying Health Care Expenses Reimbursement**

(a) A Participant who has elected benefits under the Medical FSA for a Coverage Period may apply to the Plan Administrator or its designated representative for reimbursement of Qualifying Health Care Expenses Incurred during the Coverage Period or Grace Period (if applicable). The Participant must submit claims so they are received by the Plan Administrator no later than March 31 following the end of the Coverage Period and the Grace Period in which the Qualifying Health Care Expense was Incurred. The claim for reimbursement may be made before or after the Participant has paid the Qualifying Health Care Expense, but not before the Participant has Incurred the Qualifying Health Care Expense.

(b) In the event any Qualifying Health Care Expenses are Incurred during the Grace Period, and the Participant has elected to enroll in a Medical FSA for the current Plan Year, the claim shall be reimbursed first from any balance remaining for the preceding Plan Year and second from any balance remaining from the current Plan Year.

(c) The Participant shall submit with the application relevant bills, receipts, or other statements with respect to the Qualifying Health Care Expense, together with any additional documentation that the Plan Administrator or its designated representative may request. However, a Participant who chooses to use an authorized Medical FSA debit card to attempt to purchase a Qualifying Health Care Expense is required to submit relevant bills, receipts, or other statements to verify the expense is a Qualifying Health Care Expense only upon request by the Plan Administrator.

**Section 6.06. Reimbursement of Qualifying Health Care Expenses**

If a Participant submits a claim and documentation as required by Section 6.05, and the Plan Administrator or its designated representative approves the claim, the Plan shall reimburse the Participant from the Participant's Medical FSA for Qualifying Health Care Expenses Incurred during the Coverage Period or Grace Period at such times as the Plan Administrator shall prescribe, but no less frequently than monthly. The amount of any reimbursement hereunder shall not exceed the annualized amount credited to the Participant's Medical FSA at the time of the reimbursement, less amounts previously reimbursed.

**Section 6.07. Cessation of Participant and/or Dependent Status**

Subject to Section 6.08, a Participant who ceases to be a Participant, as provided in Section 3.02, during a Plan Year shall be entitled to reimbursement of Qualifying Health Care Expenses from his or her Medical FSA only to the extent provided in this Section.

(a) A Participant who ceases to be a Participant, as provided in Section 3.02, during a Plan Year or within the Grace Period shall be entitled to reimbursement of Qualifying Health Care Expenses Incurred during the Plan Year or within the Grace Period, but before he or she ceased to be a Participant, to the same extent as if he or she were still a Participant. For the Medical FSA, participation ends on the last day of the month in which the Third-Party Administrator receives the participant's last contribution. Participants receiving continuation coverage under Section 6.08 and

Participants who were Participants on the last day of the Plan Year, but terminated during the Grace Period, are Participants for the purposes of the Grace Period.

(b) To the extent a Participant ceases making contributions to the Medical FSA while on unpaid FMLA or USERRA leave pursuant to the provisions contained in Section 3.04, such person shall not be entitled to reimbursement of Qualifying Health Care Expenses Incurred during the period while such person ceased making contributions to the Medical FSA during such unpaid FMLA or USERRA leave. Upon return from such leave during the same Plan Year, such Participant may either: (i) resume coverage at the level in effect before the FMLA or USERRA leave, and make up any unpaid contributions through a corresponding increase in contributions for the balance of the Coverage Period; or (ii) resume coverage at a level that is reduced on a pro rata basis for the period during which required contributions were not made, and resume contributions at the level in effect prior to the FMLA or USERRA leave. Regardless of whether the Participant resumes participation under (i) or (ii) in the previous sentence, the Participant's coverage level shall be reduced by any prior reimbursements during the Plan Year (whether made before or after the FMLA or USERRA leave).

(c) A Participant shall not be entitled to reimbursement for Qualifying Health Care Expenses Incurred by a Participant's FSA Dependent after the person ceases to be a FSA Dependent.

**Section 6.08. Continuation Coverage**

If a person ceases to be a Participant and agrees to make the contribution for Continuation Coverage, the person shall be treated as a Participant to the extent required by law, and coverage under the Medical FSA shall continue as long as such contributions are paid through the Third-Party Administrator, if applicable, but not beyond the end of the Plan Year in which the person ceased to be a Participant and the next Grace Period to the extent required by law, subject to the terms and conditions of the Plan. Continuation Coverage under the Medical FSA shall be administered pursuant to Article XII.

**Section 6.09. Qualified Reservist Distribution**

(a) If a Participant has unused funds in his or her Medical Flexible Spending Arrangement at the end of the Plan Year, and the Participant meets the requirements for and requests a Qualified Reservist Distribution, then the plan shall pay the amount contributed to the Medical Flexible Spending Arrangement as of the date of the Qualified Reservist Distribution request, minus any prior Medical Flexible Spending Arrangement reimbursements received during the Plan Year.

(b) A Participant may continue to receive reimbursement for Qualifying Health Care Expenses Incurred during the period of coverage for which an election is in force, prior to the date of a Qualified Reservist Distribution request. After a Qualified Reservist Distribution request, the Plan Administrator will terminate the right to submit further claims.

(c) A Qualified Reservist Distribution may not be made with respect to amounts: (i) attributable to a prior Plan Year (including a Plan Year ending on or before June 18, 2008); or attributable to non-Medical Flexible Spending Arrangements.

## ARTICLE VII
## ARTICLE VII. DEPENDENT CARE ASSISTANCE PROGRAM

**Section 7.01. Establishment of Dependent Care Assistance Program**

The Plan Administrator, or its designated representative, shall maintain a separate Dependent Care Assistance Program account for each Plan Year with respect to each Participant who has elected to make contributions to a DCAP pursuant to Article IV. DCAPs shall be maintained for bookkeeping purposes only, and except as otherwise required by law, amounts credited to a Participant's Plan Year DCAP shall remain part of the general assets of the Employer until paid pursuant to this Article. No interest or other earnings shall be credited to any Participant's DCAP.

**Section 7.02. Crediting of a DCAP**

(a) There shall be credited to a Participant's DCAP, as of each payroll date, the amount the Participant has elected to have his or her Compensation reduced by pursuant to Section 4.0l(b) for the Coverage Period for the reimbursement of Dependent Care Expenses.

(b) The minimum annual amount that must be credited to a Participant's DCAP shall be $240. The maximum Participant contribution to the DCAP is the lesser of:

(1) The Earned Income of either the Participant or the Participant's spouse, whichever is less. The term "Earned Income" in this Section means wages, salaries, tips, and other employee compensation plus any net earnings from self-employment;

(2) $5,000 annually if the Participant is single, or is married and will file a joint federal income tax return with his or her spouse for the Plan Year; or

(3) $2,500 annually for each Participant if the Participant is married and will file separate federal income tax returns for the Plan Year.

(c) Notwithstanding the limits on the amount of reimbursements available under the DCAP otherwise imposed under this Section, amounts elected by a Participant to be credited to the DCAP for a Plan Year that a Participant is required to include in the Participant's income under Code 26 U.S.C. § 129(a)(2)(B) may be used to reimburse Dependent Care Expenses pursuant to Sections 7.03 and 7.06 or may be forfeited pursuant to Section 7.04, as applicable.

**Section 7.03. Debiting of DCAP**

As of the date of any payment under this Article to or for a Participant's benefit for Dependent Care Expenses Incurred during a Coverage Period, the Participant's DCAP shall be debited by the amount of the payment. If the Dependent Care Expense exceeds the credit balance in the DCAP of a Participant, the amount to be paid to the Participant shall be reduced to zero; provided, however, if the Participant had an election for Compensation reduction in effect at the time the expense that generated the approved claim was paid, a record of any such unpaid Dependent Care Expenses shall be maintained, and thereafter, if there is a claim balance in the DCAP of the Participant during the Plan Year, the Participant shall be paid an amount equal to the lesser of: (i) any such unpaid Dependent Care Expenses; or (ii) such credit balance in the DCAP of the Participant, and the DCAP shall be debited by the amount of such payment.

### Section 7.04. Forfeiture of DCAP Funds

Except as provided under Section 7.07, the amount credited to a Participant's DCAP shall only be used to reimburse the Participant for Dependent Care Expenses Incurred during the Coverage Period while a Participant, and only if the Participant applies for reimbursement by March 31 following the end of the applicable Coverage Period. Any balance credited to a Participant's DCAP after all reimbursements for the Coverage Period have been made hereunder shall be forfeited as of March 31 following the end of the Coverage Period. Such amounts shall be forwarded to the Authority and used to pay expenses and fees of the Plan or for such other use as determined by the Plan Administrator.

### Section 7.05. Claims for Dependent Care Reimbursement

A Participant who has elected benefits under the DCAP for a Coverage Period may apply to the Plan Administrator for reimbursement of Dependent Care Expenses Incurred during the Coverage Period while a Participant by submitting a written claim to the Plan Administrator not later than March 31 after the end of the Coverage Period in which the Dependent Care Expenses were Incurred. In order to be reimbursed, all Dependent Care Expenses must have been Incurred by no later than December 31 of the Coverage Period. The claim for reimbursement may be made before or after the Participant has paid the Dependent Care Expenses, but not before the Participant has Incurred the Dependent Care Expenses.

### Section 7.06. Reimbursement of Dependent Care Expenses

If a Participant submits a claim and documentation as required by Section 7.05, and the Plan Administrator approves the claim, the Plan shall reimburse the Participant from the Participant's DCAP for Dependent Care Expenses incurred during the Coverage Period at such times as the Plan Administrator shall prescribe, but no less frequently than monthly. The amount of any reimbursement hereunder shall not exceed the amount credited to the Participant's DCAP at the time of the reimbursement.

### Section 7.07. Cessation of Participation

A Participant who ceases to be a Participant, as provided in Section 3.02, during a Plan Year shall be entitled to reimbursement of Dependent Care Expenses Incurred before the end of the Plan Year during which he or she ceased to be a Participant. The reimbursement of Dependent Care Expenses Incurred before the end of the Plan Year, however, will not exceed the credit balance in the DCAP as of the time the Participant ceased participation in the Plan.

## ARTICLE VIII
## ARTICLE VIII. BSA PARTICIPATION AND TERMINATION

### Section 8.01. Commencement of Participation and Contributions

(a) An HSA Eligible Employee shall automatically be eligible to make and receive contributions to an HSA upon enrollment in medical coverage in a CDHP in accordance with the limits in Section 8.03.

(b) No contributions may be made to the HSA for any month in which a Participant does not meet the requirements of an HSA Eligible Employee.

(c) The Participant's HSA can be funded with contributions from the Employer, the Participant, or other sources as provided below.

(1) Upon enrolling in a CDHP, the Participant's Employer may, in its discretion, make equal, monthly contributions to the Participant's HSA during the Coverage Period. Employer contributions to an HSA will be made through the Plan. The monthly contribution sum is the total contribution the Employer makes to a Participant's HSA during the Plan Year divided by twelve. The total contribution the Employer will make for the Plan Year depends on whether the Participant is the sole enrollee in his or her CDHP, or whether the Participant has at least one enrolled Dependent. The Employer's annual HSA contributions shall be published annually during or before the Annual Open Enrollment period.

(2) Both Employer and Participant contributions made to an HSA through the Plan may only be made to an HSA linked with enrollment in a PEBB CDHP. If a Participant is enrolled in another non-PEBB CDHP, another HSA, or both, his or her Employer cannot make contributions to the non-PEBB HSA and Participant contributions to such non-PEBB HSA may not be made through the Plan.

(3) Contributions to HSAs linked with enrollment in a PEBB CDHP will be made to the HSA Trust Custodian. Any contributions remaining in an HSA at the end of a Plan Year will be subject to the terms and conditions of the HSA as set forth by the HSA Trust Custodian.

(4) The Employer, PEBB, or the Plan Administrator may require such documentation that they deem necessary to confirm that an individual is an HSA Eligible Employee prior to making contributions to such individual's HSA.

(d) The Participant is responsible for verifying his or her eligibility to establish and contribute to an HSA. The Participant is solely responsible for complying with any applicable contribution limits in effect under the law with respect to the HSA. The maximum combined amount, from all contribution sources, that may be contributed to all HSAs maintained by a Participant each calendar year shall not exceed the maximum amount permitted under Code Section 223(b), as modified by any cost-of-living adjustment under Code Section 223(g)

(e) The maximum amount that may be credited to an HSA for any Coverage Period is not available as of the date the Participant enrolls in a PEBB CDHP. Funds from an HSA are only available to pay for HSA Qualified Medical Expenses after they are contributed to the HSA.

**Section 8.02. Modifying BSA Elections**

A Participant who elects to make HSA contributions may start or stop the election, or increase or decrease the election, at any time by submitting the completed required form to his or her State Agency, or by following any other administrative procedure as determined by the Plan Administrator. Any change in HSA election will be prospective and take effect no later than the first day of the month following the date when the Participant requested to change an HSA election. The Plan Administrator may place additional restrictions on the election of HSA contributions; provided, however, that the

same restrictions apply to all Participants. The special open enrollment events and irrevocability rules set forth in Sections 4.04 through 4.11 of the Plan shall not apply to elections to modify HSA contribution elections.

**Section 8.03. Prohibition on Simultaneous Enrollment** in **HSA and Medical FSA**

(a) Notwithstanding any other provision of the Plan, a Participant may not be simultaneously enrolled in an HSA and Medical FSA under the Plan in the same Coverage Period. Funds from a Medical FSA may not be deposited in an HSA as contributions.

(b) The Plan Administrator will resolve the simultaneous enrollment of a Participant in an HSA and Medical FSA in the same Coverage Period as follows:

. (1) If a Participant submits an election under Section 4.02 (whether as an initial election under Section 4.02(b), an Annual Open Enrollment election under Section 4.02(d), or a special open enrollment election under Section 4.02(e)) for both a CDHP with an HSA and a Medical FSA for any part of the same Coverage Period, the Plan Administrator shall recognize the election for a CDHP with an HSA, and shall cancel the election for a Medical FSA pursuant to Section 4.13(d).

(2) If a Participant is enrolled in a Medical FSA during the preceding Coverage Period, will be enrolled in a CDHP with an HSA in the current Coverage Period, and has any funds remaining in the Medical FSA after December 31st of the preceding Coverage Period, then the Participant may not contribute to or receive contributions for the HSA under the Plan until the first of the month following the end of the Grace Period.

(3) If a Participant is enrolled in a Medical FSA during a Coverage Period, and then elects to enroll in a CDHP with a HSA for the same Coverage Period following a special open enrollment pursuant to Section 4.02(e), no contributions may be made to the HSA for the remainder of such Coverage Period. The Participant shall have no right to any further Employer HSA contributions for the remainder of such Coverage Period. If any funds remain in a Participant's Medical FSA after December 31st of the Coverage Period, the Participant may not contribute to, or receive contributions for, an HSA under the Plan until the first of the month following the end of the Grace Period.

(c) A Participant who is enrolled in a CDHP with an HSA under the Plan may enroll in a Medical FSA for the following Coverage Period if the Participant is not enrolled in the CDHP with an HSA for such following Coverage Period.

**Section 8.04. HSA Comparability Rules**

Contributions made to a Participant's HSA linked to a PEBB CDHP by an Employer through the Plan are not subject to the comparability rules in Code Section 4980G.

## ARTICLE IX
## ADMINISTRATION OF THE PLAN

**Section 9.01. Plan Administrator**

The Authority shall be the Plan Administrator of the Plan; provided, however, the Authority may, from time to time, designate a person, committee, or organization, including, but not limited to a Third-Party Administrator or State Agency, to perform certain administrative functions. Any such individual, committee, or organization shall hold office until removed by the Authority, which removal may be without cause and without advance notice. The Authority shall have full, discretionary authority to control and manage the operation and administration of the Plan and shall be the mimed fiduciary of the Plan. The Authority shall have all power necessary or convenient to enable it to exercise such power. The Authority may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan and may from time to time, amend or rescind such rules or regulations. The Authority shall have full discretion, power, and duty to take all action necessary or proper to carry out its duties required by law or this Plan. The Authority is authorized to accept service of legal process for the Plan.

**Section 9.02. Questions of Interpretation**

The Plan Administrator shall have full, discretionary authority to enable it to carry out the terms of the Plan, including but not limited to, the authority to determine eligibility under the Plan, construe the terms of the Plan, and determine all questions of fact or law arising hereunder. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby. The Plan Administrator shall have full, discretionary authority to correct any defect, supply any omission, or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as the Plan Administrator may deem expedient. The Plan Administrator shall be the sole and final judge of such expediency. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion a Participant is entitled to them.

**Section 9.03. Claims and Appeals Procedures**

(a) Initial claims for benefits under the Medical FSA and DCAP shall be made directly to the Third-Party Administrator pursuant to Sections 6.05 and 7.05, respectively. Any Participant aggrieved by a decision regarding the Medical FSA or DCAP may appeal that decision to the Third-Party Administrator under reasonable procedures developed by the Third- Party Administrator for such purposes.

(b) Any Participant who disagrees with a decision in response to an appeal filed with the Third-Party Administrator that administers the Medical FSA and DCAP may appeal to the PEBB Appeals Unit. The PEBB Appeals Unit must receive the appeal no later than thirty days after the date of the appeal decision by the Third-Party Administrator that administers the Medical FSA and DCAP. The PEBB Appeals Unit shall notify the Participant in writing when the appeal has been received. Generally, a Presiding Officer will render an Initial Order within ten business days of receiving the appeal. The PEBB Program or the Participant may request a continuance, extending the ten day requirement for rendering a decision. The Presiding Officer, on their own motion, may extend the ten day requirement for rendering a decision and request additional documents, if needed. The written decision shall be sent to the Participant. Any participant who disagrees with the Initial Order issued by a Presiding Officer may request review of that decision, as described in subsection (g) below.

(c) Any Employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under this plan may appeal that decision by submitting a written request for

review to their State Agency. The State Agency must receive that request no later than 30 days after the date of the denial. If the employee disagrees with the decision made by their State Agency, they may appeal that decision to the PEBB Appeals Unit. The PEBB Appeals Unit must receive the appeal no later than 30 days after the date of the denial notice from the state agency. The Employee's appeal should comply with subsection (d) below. The PEBB Appeals Unit shall notify the Employee in writing when the appeal has been received. Generally, the Presiding Officer shall render an Initial Order within ten business days of receiving the appeal. The PEBB Program or the Employee may request a continuance, extending the ten day requirement for rendering a decision. The Presiding Officer, on their own motion, may extend the ten day requirement for rendering a decision and request additional documents, if needed. The Initial Order shall be sent to the Employee. Any Employee who disagrees with the Initial Order issued by a Presiding Officer may request review of that decision, as described in subsection (f) below.

(d) A notice of appeal filed by a Participant or an Employee with the PEBB Appeals Unit under subsections (b) or (c) above should contain the following elements:

(1) The name and mailing address of the appealing party if any;

(2) The name and mailing address of the appealing party's representative, if

(3) Documentation, or reference to documentation, of decisions previously rendered through the appeal process, if any;

(4) A statement identifying the specific portion of the decision being appealed and clarifying what is believed to be unlawful or in error;

(5) A statement of facts in support of the appealing party's position;

(6) Any information or documentation that the appealing party would like considered and substantiates why the decision should be reversed. Information or documentation submitted at a later date, unless specifically requested by the PEBB Appeals Unit, may not be considered in the appeal decision;

(7) The type of relief sought;

(8) A statement that the appealing party has read the notice of appeal and believes the contents to be true; and

(9) The signature of the appealing party or the appealing party' s representative.

(e) Any Participant or Employee who disagrees with an Initial Order issued by a Presiding Officer in response to their appeal has the right to request review of that decision. The PEBB Appeals Unit must receive the Participant's or Employee's request for review within twenty-one days of the date the Initial Order was served (service is defined in WAC 182-16-058). The Participant's request for review may be made orally to the PEBB Appeals Unit or in writing, as described in WAC 182-16-2100. A review of the Initial Order will be performed by a Review Officer or Officers. The Review Officer or Officers shall render a Final Order within twenty days of receiving the request for review. The Final Order shall be sent to the Participant or Employee.

(f) Any Participant or Employee who disagrees with a Final Order issued by a Review Officer or Officers may seek reconsideration or judicial review. Reconsideration asks the Review Officer or Officers to reconsider the Final Order because the party believes the Review Officer or Officers made a mistake of law, mistake of fact, or clerical error. A request for reconsideration must be in writing and filed with the PEBB Appeals Unit within ten days of service of the Final Order. A Participant or Employee does not have to seek reconsideration before they are able to request judicial review. Judicial review is the process of appealing a Final Order to Superior Court. A Participant or Employee pursuing judicial review should consult requirements in RCW 34.05.510 through RCW 34.05.598.

(g) The Presiding Officer or Review Officer or Officers may convert a Brief Adjudicative Proceeding (BAP)to a formal administrative hearing at any time. An appeal must be converted to a formal administrative hearing when the interest and issues involved in the controversy warrant the use of procedures in RCW 34.05.413 through RCW 34.05.479. When a BAP is converted to a formal administrative hearing, the director may become the Hearing Officer or may designate a replacement hearing officer to conduct the formal administrative hearing upon notice to the Participant or Employee and PEBB. The Hearing Officer will generally render a Final Order within ninety days after the record is closed. The Final Order shall be sent to the Participant. Formal administrative hearings are conducted consistent with the Administrative Procedure Act, chapter 34.05 RCW 34.05.413 through43.05.479 and PART III of chapter 182-16 WAC.

## ARTICLEX
## PROTECTED HEALTH INFORMATION

**Section 10.01. Adoption and Effective Date of Article**

This Article is adopted to reflect certain provisions of HIPAA. This Article is intended as good faith compliance with the requirements of HIPAA and is to be construed in accordance with HIPAA and guidance issued thereunder. This Article shall apply only to Protected Health Information related to the Medical FSA under this Plan.

**Section 10.02. Supersession of Inconsistent Provisions**

This Article shall supersede the provisions of Article VI to the extent those provisions are inconsistent with the provisions of this Article.

**Section 10.03. Use and Disclosure of Protected Health Information**

The Medical FSA shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations and the Security Regulations, and by the Washington. State Uniform Health Care Information Act (Chapter 70.02 RCW). Specifically, the Medical FSA shall useand disclose Protected Health Information for purposes related to health care treatment, Payment for health care related to the Medical FSA, and the Health Care Operations of the Medical FSA.

(a) For this Article, "Payment" means "payment" as defined by 45 § CFR 164.501, as amended, but limited to Payment activities related to the Medical FSA.

(b) For this Article, "Health Care Operations" means "health care operations" as defined by 45 CFR § 164.501, as amended, but limited to the Health Care Operations related to the Medical FSA.

**Section 10.04. Safeguards**

The Authority shall adopt reasonable administrative, physical, and technical safeguards to protect the privacy and security of Protected Health Information received or disclosed in connection with operating the Medical FSA.

**Section 10.05. Disclosures by the Medical FSA to the Authority**

The Plan Administrator, or its designated representative, for the Medical FSA may:

(a) Disclose Summary Health Information to the Authority, if the Authority requests the Summary Health Information for the purpose of: (1) obtaining premium bids from health plans for providing coverage under the Plan; or (2) modifying, amending, or terminating the Medical FSA;

(b) Disclose to the Authority information on whether an individual is participating in the Medical FSA;

(c) Disclose Protected Health Information to the Authority to carry out the plan administration functions that the Authority performs, consistent with the provisions of Sections. 10.05 to 10.07 of this Article. For these purposes, "plan administration functions" are the functions performed by the Authority on behalf of the Medical FSA and excludes functions performed by the Authority in connection with any other benefit or benefit plan of the Authority;

(d) Only with an authorization from the Participant, disclose Protected Health Information to the Authority for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Authority;

(e) Not disclose (and may not permit another to disclose) Protected Health Information to the Authority as otherwise permitted by this Section unless a statement is included in the Medical FSA's notice of privacy practices that the Medical FSA Plan may disclose Protected Health Information to the Authority; and

(f) Not disclose Protected Health Information to the Authority or an Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan.

**Section 10.06. Uses and Disclosures by Authority**

The Authority may only use and disclose Protected Health Information as permitted and required by the Medical FSA, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The Authority may use and disclose Protected Health Information without an authorization from a Participant for Medical FSA administrative functions including Payment activities and Health Care Operations. In addition, the Authority may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Section 10.05.

**Section 10.07. Certification**

The Plan Administrator, or its designated representative, for the Medical FSA may disclose Protected Health Information to the Authority only upon receipt of a certification from the Authority that the Authority so agrees to the provisions set forth therein.

**Section 10.08. Conditions Agreed by the Authority**

The Authority agrees to:

(a) Not use or further disclose Protected Health Information other than as permitted or required by the Medical FSA documents or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Authority provides Protected Health Information received from the Medical FSA agree to the same restrictions and conditions that apply to the Authority with respect to such Protected Health Information; ·

(c) Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;

(d) Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Authority unless authorized by an individual;

(e) Report to the Plan Administrator, or its designated representative, for the Medical FSA any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make Protected Health Information available to an individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524 and all other applicable federal and state law;

(g) Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CPR § 164.526 and all other applicable federal and state law;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 CPR § 164.528 and all other applicable federal and state law;

(i) Report any security incident involving the Medical FSA of which it becomes aware;

(j) Make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(k) If feasible, return or destroy all Protected Health Information received from the Plan that the Authority still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

(1) The Authority agrees to comply with. the HIPAA Privacy Rule as to functions required by the rule that it is performing for the Plan, and with all applicable provisions of the Washington State Uniform Health Care Information Act (Chapter 70.02 RCW).

**Section 10.09.Adequate Separation Between the Plan and the Authority**

In accordance with HIPAA, and all other applicable federal and state law, only the Authority's Privacy Officer and employees of the Authority who need access to Protected Health Information necessary to enforce the privacy policies and procedures of the Medical FSA, or as necessary to perform any administrative functions of the Medical FSA, including, but not limited to, adjudicating claims and appeals may be given access to Protected Health Information. In his or her discretion, the Privacy Officer may, from time to time, designate other individuals who need access to Protected Health Information to perform permissive administrative functions on behalf of the Medical FSA. The Privacy Officer shall designate such individuals and define the Protected Health Information they may use.

**Section 10.10.Limitations of Access and Disclosure**

The persons described in Section 10.09 of this Article may only have access to use and disclose Protected Health Information for Plan administration functions that the Authority performs for the Medical FSA.

**Section 10.11.Noncompliance**

If the persons or classes of persons described in Section 10.09 of this Article do not comply with this Plan document, the Authority shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

## ARTICLE XI
## AMENDMENT AND TERMINATION

**Section 11.01. Amendment**

The Authority shall have the right, in its sole discretion, to amend the Plan, in whole or in part, at any time and to any extent the Authority may deem advisable. Any amendment of the Plan shall be effective upon the date of approval or such later date as the Authority may determine in connection therewith. To the extent allowed by applicable law, any such modification and/or amendment may be effective retroactively.

**Section 11.02. Termination**

The Employer shall have the right, in its sole discretion, to terminate the Plan at any time it may deem advisable. Termination shall be effective upon the date determined by the Employer and will be implemented by the Authority. To the extent allowed by applicable law, any such termination may be effective retroactively.

## ARTICLE XII
## CONTINUATION OFCOVERAGE

The following Continuation Coverage provisions, along with Section 6.008, shall apply with respect to the Participant's Medical FSA.

**Section 12.01. Qualified Beneficiary**

Only Qualified Beneficiaries may elect Continuation Coverage under the Plan after a Qualifying Event. For purposes of this Article, a "Qualified Beneficiary" is a person who is covered under the Medical FSA on the day before a Qualifying Event who is:

(a) A Participant who is covered under the Medical FSA (hereinafter referred to in Article XII as "Covered Employee");

(b) A Spouse of a Covered Employee; or

(c) An FSA Dependent child of a Covered Employee (including a child born to or placed for adoption with the Covered Employee while the Covered Employee is covered under Continuation Coverage).

**Section 12.02. Qualifying Events**

The right to Continuation Coverage is triggered by any of the following Qualifying Events, which, but for the Continuation Coverage, would result in a loss of coverage under the Medical FSA. For purposes of this Article, a "Qualifying Event" occurs upon:

(a) The death of the Covered Employee;

(b) The termination (other than by reason of gross misconduct) of the Covered Employee's employment, or reduction of hours of a Covered Employee that would result in a termination of coverage under the Medical FSA;

(c) The divorce of the Covered Employee from the Covered Employee's Spouse;

(d) A child of the Covered Employee ceasing to be an FSA Dependent child under the eligibility requirements; or

(e) The Covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare).

**Section 12.03. Election of Continuation Coverage**

Continuation Coverage will not be offered, and may not be elected, if the maximum premium required to be paid for Continuation Coverage under Section 12.06 equals or exceeds the maximum benefits available under the Medical FSA for the remainder of the Plan Year. Continuation Coverage does not begin unless it is elected by a Qualified Beneficiary. The election period shall begin on or before the date that the Qualified Beneficiary would lose coverage under the Medical FSA due to the Qualifying Event, and shall not end before the date that is sixty (60) days after the later of: (i) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or (ii) the date on which notice of the right to continued coverage is sent by the Authority or its designee. The election of Continuation Coverage must be made on a form provided by the Authority or its designee and

payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Authority or its designee. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Event shall have an independent right to elect Continuation Coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage.

**Section 12.04. Period of Continuation Coverage**

COBRA Coverage under the Medical FSA shall extend only until the end of the Plan Year (including any applicable Grace Period) in which the Qualified Beneficiary's Qualifying Event occurs.

**Section 12.05. End of COBRA Coverage**

Continuation coverage shall end earlier than the period designated under Section 12.04 if:

(a) Timely payment of premiums for the continuation coverage is not made;

(b) The Qualified Beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA) with respect to any pre-existing condition of the Qualified Beneficiary;

(c) The State Agency ceases to provide any group health plan to any Employee;

(d) The Qualified Beneficiary ceases to be disabled, if continuation coverage is due to the disability;

(e) The period of Continuation Coverage expires; or

(f) As provided under Section 6.07.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

**Section 12.06. Cost of Continuation Coverage**

The Qualified Beneficiary is responsible for paying the cost of Continuation Coverage, which is referred to in this Article XII as the "premium" plus any applicable premium surcharges. The premiums and any applicable premium surcharges are payable on a monthly basis. After a Qualifying Event, a notice shall be provided which shall specify the amount owed, to whom the amount is to be paid, and the date each month's payment is due. Failure to pay the amount owed on a timely basis shall result in termination of coverage as of the last month in which a full payment was timely made. Payment of any amounts, other than that referred to below, shall only be considered timely if made within thirty (30) days after the date due. The required amounts must be paid for the cost of Continuation Coverage for the time period between the date of the event, which triggered Continuation Coverage and the date Continuation Coverage is elected. This payment must be made

within forty-five (45) days after the election period ends. Failure to pay this amount on the date due shall result in cancellation of coverage back to the initial date coverage would have been terminated.

**Section 12.07. Notification Requirements**

(a) Initial Notice to Covered Employee and Spouse. The Plan shall provide, at the time of commencement of coverage, written notice to each Covered Employee and to the Spouse of the Covered Employee (if any) of their rights to Continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to a Covered Employee and any other Qualified Beneficiary who all reside at the Covered Employee's address, and the Spouse's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this initial notice must be provided under this subparagraph (a).. No separate notice is required to be sent to FSA Dependents who share a residence with a Covered Employee or a Covered Employee's Spouse. This initial notice shall be provided not later than the earlier of: (i) ninety (90) days after such individual's coverage commencement date under the Plan; or (ii) the date on which the Authority is required to furnish a COBRA election notice as described in subparagraph (d) of this Section.

(b) State Agency Notice to Authority. . Within thirty (30) days after the date of the Qualifying Event, the State Agency shall notify the Authority or its designee in the event of a Covered Employee's: (i) death; (ii), termination of employment (other than for gross misconduct);
(iii) reduction in hours; or (iv) entitlement to Medicare benefits.

(c) Covered Employee /Qualified Beneficiary Notice to Authority. The Covered Employee or Qualified Beneficiary must notify the Authority or its designee of: (i) a divorce of the Covered Employee from the Covered Employee's Spouse; or (ii) an FSA Dependent child ceasing to be an FSA Dependent child under the eligibility requirements of the Plan. Notification must occur as soon as possible, but not later than sixty (60) days after the later of: the date of such Qualifying Event; (ii) the date that the Qualified Beneficiary loses or would lose coverage due to such Qualifying Event; or (iii) the date on which the Qualified Beneficiary is informed, by the Plan(s) of the Qualified Beneficiary's obligation to provide such notice and the Plan procedures for providing such notice.

The Covered Employee, Qualified Beneficiary, or a representative acting on behalf of the Covered Employee or Qualified Beneficiary, may provide such notice. The provisions of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event. Failure to provide such timely notice shall result in the loss of any right to elect Continuation Coverage.

The Plan shall establish reasonable procedures for the furnishing of the notice described above and shall publish such procedures for Participants. A Qualified Beneficiary's failure to follow such procedures within the times prescribed above shall result in a denial of Continuation Coverage.

(d) Authority Notice to Qualified Beneficiary. Upon receipt of a notice of Qualifying Event under subsections (b) or (c), _the Authority or its designee shall provide to each Qualified Beneficiary notice of their right to elect Continuation Coverage no later than fourteen (14) days after the date on which the Authority or its designee received notice of these Qualifying Events. Any notification to a Qualified Beneficiary who is the Spouse of the Covered Employee shall be treated

as a notification to all other Qualified Beneficiaries residing with such Spouse at the time such notification is made.

(e) Unavailability of Coverage. If the Authority or its designee receives a notice of an applicable Qualifying Event under subsection (c) and determines that the person is not entitled to Continuation Coverage, the Authority shall notify the person with an explanation as to why such coverage is not available within the time frame designated under subsection (d) above.

(f) Notice of Termination of Coverage. The Authority or its designee shall provide notice to each Qualified Beneficiary of any termination of Continuation Coverage which is effective earlier than the end of the maximum period of Continuation Coverage applicable to such Qualifying Event, as soon as practicable following the Authority's determination that Continuation Coverage should terminate.

(g) Use of a Single Notice. Notices required under subsections (d), (e) and (f), must be provided to each Qualified Beneficiary or individual, however: (i) a single notice can be provided to the Covered Employee and the Covered Employee's Spouse if the Covered Employee Spouse resides with the Covered Employee; and/or (ii) a single notice can be provided to the Covered Employee or the Covered Employee's Spouse for an FSA Dependent child of the Covered Employee, if the FSA Dependent child resides with the Covered Employee or the Covered Employee's Spouse.

**Section 12.08. Continuation Health Benefits Provided.**

The Continuation Coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided under the Medical FSA pursuant to the Plan for similarly situated persons covered by the Plan with respect to whom a Qualifying Event has not occurred. If coverage is modified under the Medical FSA under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are Qualified Beneficiaries under the Medical FSA pursuant to the Plan. Continuation Coverage may not be conditioned on evidence of good health. If the Plan provides an Annual Open Enrollment period during which similarly situated active employees may choose to be covered under the Medical FSA of the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to Qualified Beneficiaries who have elected Continuation Coverage.

## ARTICLE XIII
## MISCELLANEOUS

**Section 13.01. Additional Taxes or Penalties**

If there are any taxes or penalties payable by the Employer on behalf of any Participant, such taxes or penalties shall be payable by the Participant to the Employer to the extent such taxes would have been originally payable by the Participant had this Plan not been in existence.

**Section 13.02.Report to Participants on or Before January 31 of Each Year**

On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received DCAP reimbursement during the prior Plan Year a written statement showing the amount of all DCAP reimbursements paid to or on behalf of the Participant during the prior Plan Year.

**Section 13.03.No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan shall be excludable from the Participant's gross income for federal, state, or local income tax purposes or for Social Security or Medicare tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Participant. , It shall be the obligation of each Participant to determine whether payment under the Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and Social Security and Medicare tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not excludable.

**Section 13.04. Indemnification of Employer and Authority**

If a Participant receives one or more reimbursements under his or her Medical FSA that are not for Qualifying Health Care Expenses, or under his or DCAP that are not for Dependent Care Expenses (including, but not limited to, instances in which a Participant erroneously submits claims for individuals who are not FSA Dependents or Qualifying Individuals as defined by the Plan), the Participant shall indemnify and reimburse the Authority or Employer for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security or Medicare tax from the reimbursements; provided, however, the Participant's indemnification and reimbursement shall not exceed the amount of additional federal, state, or local income tax that the Participant would have owed if the reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security or Medicare tax that would have been paid on that compensation, less any such additional income and Social Security or Medicare tax actually paid by the Participant.

**Section 13.05. Eligibility for Medicaid Benefits**

Benefits shall be paid in accordance with any assignment of rights made by or on behalf of any Participant or dependent as required by a state plan for medical assistance approved under Title XIX, section 1912(a)(l)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a Participant's or dependent's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account. The Employer shall have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

**Section 13.06. FMLA and USERRA**

The Plan shall comply with the requirements under the FMLA and USERRA.

**Section 13.07. HIPAA and PDSA Compliance**

To the extent required under HIPAA and PHSA, the Plan shall comply with the requirements under HIPAA and PHSA including: (i) compliance with certain special enrollment periods; (ii) nondiscrimination benefits requirements; and (iii) privacy and security requirements (as described in Article IX) to the extent required and to the extent not otherwise inconsistent with the requirements under Code Section 105 and any regulations issued thereunder.

### Section 13.08. State Law Compliance

To the extent required, the Plan shall comply with all applicable requirements under state law.

### Section 13.09. Limitation of Rights and Obligations

Neither the establishment nor maintenance of the Plan, nor any amendment thereof, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

(a) As conferring upon any Participant, dependent, beneficiary, or any other person a right or claim against the Employer or the Plan Administrator, except to the extent that such right or claim shall be specifically expressed or provided in the Plan or provided by applicable law;

(b) As creating any responsibility or liability of the Employer or the Plan Administrator for the validity or effect of the Plan;

(c) As a contract or agreement between the Employer or Authority and any Participant or other person;

(d) As being consideration for, or an inducement or condition of, employment of any Participant or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Participant or other person to continue or terminate the employment relationship at any time; or

(e) As to give any Participant or other person, the right to be retained in the service of any Employer or to interfere with the right of the Employer to discharge any Participant or other person at anytime.

### Section 13.10. Forms and Proofs

Each Participant eligible to receive any benefit from the Plan shall complete all forms and furnish all proofs, receipts, and releases as may be required by any employer, the Plan Administrator, or the Plan Administrator's designated agent.

### Section 13.11. Misrepresentation

Any material misrepresentation on the part of the Participant making application for coverage or receipt of benefits shall render the coverage null and void.

### Section 13.12. Employment of Consultants

The Plan Administrator may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

### Section 13.13. Counterparts

The Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument and shall be evidenced by any one counterpart.

**Section 13.14.Notice**

Any notice given under the Plan shall be sufficient if given to the Plan Administrator or its duly designated agent, when addressed to its office; or if given to a Participant, when addressed and sent to the Participant at his or her address as it appears in the records of the Plan Administrator or its duly designated agent.

**Section 13.15. Disclaimer of Liability**

Nothing contained herein shall confer upon a Participant any claim, right, or cause of action, either at law or at equity, against the Plan, Plan Administrator, the HCA, or the Employer, for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan.

**Section 13.16. Right of Recovery**

With the exception of payments to a Participant's HSA, if the Third-Party Administrator or Plan Administrator, or one of their designees, makes any payment not in accordance with the Plan, it may recover that incorrect payment, whether or not it was made due to the Third-Party Administrator's, the Plan Administrator's, or the designee's own error, from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made directly to a Participant, the Third-Party Administrator, the Plan Administrator, or the designee may deduct it when making future payments directly to that Participant.

**Section 13.17.Evidence of Action**

All orders, requests, and instructions to the Third-Party Administrator or its designee by the Authority, or by any duly authorized representative, shall be in writing and the Third-Party Administrator or its designee shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions.

**Section 13.18. Receipt and Release**

Any payments to any Participant shall, to the extent thereof, be in full satisfaction of the claim of such Participant being paid thereby and the Plan Administrator may condition payment thereof on the delivery by the Participant of the duly executed receipt and release in such form as may be determined by the Plan Administrator.

**Section 13.19. Benefits Solely from General Assets Except as may otherwise be required by law:**

(a) The benefits provided hereunder shall be paid solely from the general assets of the Employer or the Authority;

(b) Nothing herein shall be construed to require the Plan Administrator or an Employer to maintain any fund or segregate any amount for the benefit of any Participant;

(c) No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of an Employer or the Authority from which any payment under the Plan may be made; and

(d) No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of an Employer or the Authority from which any payment under the Plan may be made.

**Section 13.20. Reliance**

The Plan Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other writing believed by the Plan Administrator to be genuine or to be executed or sent by an authorized person.

**Section 13.21. Participant Incapacitation**

When any Participant is under legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may cause the Participant's benefits to be paid to his legal representative for his or her benefit. The payment of benefits pursuant to this Section shall completely discharge the liability of the Plan for the benefits.

**Section 13.22. Participant Death**

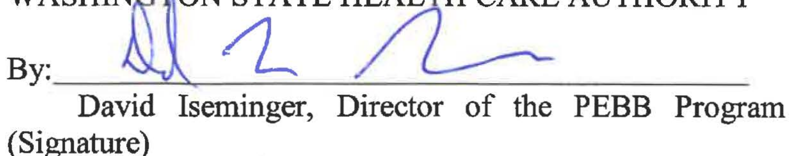
In the event of a Participant's death, the Participant's Spouse (or, if none, the Participant's executor or Plan Administrator) may apply on the Participant's behalf for reimbursement of Qualifying Health Care Expenses. The payment of benefits pursuant to this Section shall completely discharge the liability of the Program for the benefits.

**Section 13.23. Entire Plan**

The Plan document and the documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. All statements made by the Employer or the Plan Administrator shall be deemed representations and not warranties. No oral statement or other communication shall void or reduce coverage under the Plan, or amend or modify the terms of the Plan, or be used in defense to a claim, unless in writing signed by the Plan Administrator.

IN WITNESS WHEREOF, the Authority has caused this instrument to be executed by its duly authorized officers this day of 31st July 2019, to be effective as of the date identified above.

WASHINGTON STATE HEALTH CARE AUTHORITY



By:______________________________
David Iseminger, Director of the PEBB Program (Signature)

David M. Iseminger
David Iseminger, Director of the PEBB Program (Printed)

EXHIBIT A

**Employee Mistake - Factor Test**

The Plan Administrator may cancel or revise a Participant's elections to enroll in an FSA or DCAP or to switch from one PEBB health plan to another PEBB health plan, upon the establishment, by clear and convincing evidence, of a mistake of fact by the Participant when making the election. The determination of whether a mistake of fact was made shall be in the Plan Administrator's sole discretion under the factors set forth in this factor test. The Plan Administrator shall use this Factor test in only the following instances: (i) when the election in question involves a Medical FSA, (ii) when the election in question involves DCAP, or (iii) when the election in question involves a request to switch from one PEBB health plan to another PEBB health plan because the subscriber or the subscriber's dependent is experiencing a disruption of medical care that impacts a documented on-going course of treatment. The Plan Administrator may not cancel or revise a Participant's election to enroll, not enroll, disenroll, or waive coverage for the subscriber or any of the subscriber's dependents in a PEBB health plan.

**This factor test is not intended to supplement or add any additional special open enrollment events, not otherwise articulated** in **WAC Ch. 182-08 and 182-12.** If the Plan Administrator agrees that employee mistake has occurred in one of the above-listed authorized categories, any election changes shall be implemented on a retroactive basis, thereby putting the employee in the same position they would be in had they not made the mistake.

Question to ask: Considering the factors below, has the Participant established, by clear and convincing evidence, that a mistaken election was made? The Plan Administrator decides the weight of each factor and not all factors will apply in every instance.

☐ **Impossibility- Is** it actually impossible to use this benefit?

☐ **Timeliness of request** - Did the subscriber discover and appeal within a reasonable period of time? Closer in time to election, more likely to be reasonable.

☐ **Triggering Event** - Was there a triggering event that is reasonable to alert the subscriber that a mistake was made? To be used when the discovery was past a "reasonable time" for timeliness, but the length of time is reasonable due to some "triggering event". Ex. A subscriber made an annual visit to oncologist during the middle of the plan year and at this annual check-up, discovered that their oncologist was not an in-network provider.

D **History-** Does the history of the subscriber's past elections make the current election seem consistent with the subscriber's pattern of coverage? Look at past elections of a subscriber to determine if the current election is contrary to those made in the past. If the new election differs from the history of past elections, that is evidence supporting the claim of a mistaken election. Ultimately, this factor considers the frequency of past, consistent elections compared to the current election, if different.

☐ **Consequence of election** - Is the consequence of the allegedly mistaken election so devastating to the participant that no reasonable participant would have consciously

chosen to make that election, therefore it must be a mistake? This factor is not looking at whether the circumstances are devastating to the participant themselves, but rather looks at the facts from a reasonable person standard. It is important to note, that sometimes people consciously make bad decisions that have devastating effects, but they are not mistakes and a participant should not be allowed to change an election in such circumstances no matter how devastating the consequences are to the participant.

- ☐ **Use of benefit** - If the subscriber has been using a benefit this plan year, but subsequently states that they entered into that election mistakenly, having used the benefit weighs *against* a change in election.

- ☐ **Notice to the Subscriber** - If the subscriber was given ample notice of the election they made and they failed to act on it, this factor would weigh *against* a change. If, however, they should have received notices, but the program or the carrier failed to give adequate notice, then this factor would weigh in favor of allowing a change in election.

- ☐ **Diagnosis and Disruption of care** -This factor considers the subscriber's medical evidence for purposes of determining a treatment plan that either would or would not be available to the subscriber based on their election. The PEBB program relies on CQCT to perform this review and provide analysis based on the medical evidence provided. *Note: this factor only applies when the election in question involves a request to switch from one PEBB health plan to another PEBB health plan because the subscriber or the subscriber's dependent is experiencing a disruption of medical care that impacts a documented on-going course of treatment.*

For FSA/DCAP appeals, after a run out period, any money remaining in an FSA/DCAP is forfeited to the state, once remaining funds have been forfeited to the state this factor test no longer applies to the circumstances.