

FLEXIBLE BENEFIT PLAN

ARTICLE I - INTRODUCTION

1.01 The Plan

The purpose of this Plan is to provide Participants with a choice between the receipt of cash compensation and/or, dependent care benefits, and/or health care expense reimbursement benefits, and/or health savings accounts.

1.02 Applicability

The provisions of this Plan are applicable only to those eligible persons who are Employees of the Employer on or after the date the Employer adopts this Plan.

1.03 Plan Status

This Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1954.

ARTICLE II - DEFINITIONS

2.01 "Account" means the account or accounts as established for the Participant for the purpose of accounting for contributions allocated to and benefits paid to or on behalf of a Participant.

2.02 "Adoption Agreement" means the document executed by an adopting Employer.

2.03 "Affiliate" means (a) any corporation which is a member of the same controlled group of corporations (within the meaning of Section 414(b) of the Code) as is the Employer, (b) any other trade or business (whether or not incorporated) controlling, controlled by, or under common control (within the meaning of Section 414(c) of the Code) with the Employer and (c) any other organization which is a member of an affiliated service group (within the meaning of Section 414(m) of the Code) with the Employer.

2.04 "Benefit Dollars" means salary reduction benefit dollars which are the amounts credited to the Account of a Participant under this Plan, and which consists of the amount of Employer contributions attributable to reductions in Compensation as elected by a Participant, which shall be credited to the Account of the Participant.

2.05 "Code" means the Internal Revenue Code of 1954, as amended, and any successor thereto.

2.06 "Compensation" means those components of compensation selected by the Employer on the Adoption Agreement, which are paid to a Participant by the Employer during the Plan Year.

2.07 "Effective Date" means the date on which the Plan became effective as to any Employer as specified in the Adoption Agreement.

2.08 "Employee" means any person who is employed by an Employer and classified as an employee for purposes of coverage under one or more of the benefit plans maintained by the Employer.

2.09 "Employer" means the adopting employer and/or Plan Administrator.

- 2.10 "Highly Compensated Employee" means an Employee (a) who is an officer, (b) who is a shareholder owning more than 5 percent (5%) of the voting power or value of all classes of stock of the Employer, or (c) a highly compensated employee.
- 2.11 "Highly Compensated Participant" means a Participant who is a Highly Compensated Employee or a spouse or dependent thereof.
- 2.12 "Key Employee" mean an Employee who as defined in Section 416(i)(1) of the Code.
- 2.13 "Participant" means any individual who satisfies the eligibility requirements of the Plan as set forth in the Agreement for Flexible Spending Account Plan Administration and who participates in the Plan.
- 2.14 "Plan" means the Flexible Benefit Plan as set forth herein, and as may be amended from time to time.
- 2.15 "Plan Year" means the twelve (12) month period designated by the Employer in the Agreement for Flexible Spending Account Plan Administration.

ARTICLE III - ADOPTION OF PLAN

An Employer may adopt this Plan by the execution of an Adoption Agreement.

ARTICLE IV - PARTICIPATION

4.01 Eligibility for Employees

Each person who is an Employee shall become a Participant in this Plan on the date designated by the Employer in the Adoption Agreement.

4.02 Cessation of Participation

A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, or (b) the last day on which he ceases to be covered under one or more of the employee benefits plans, which provide the benefits described in Section 1.01.

4.03 Application to Participate

Each Employee who becomes eligible to participate in this Plan shall complete the forms and provide the data as required by the Employer as a condition to participate. New employees have until the Monday following the pay period in which they are hired to enroll. Elected officials and legislators must enroll by January 31st of the year following election or re-election. Employees may elect to enroll or make changes (a) during Open Enrollment period(s) designated by the State, (b) based on interim qualifying events under Section 125 of the Internal Revenue Code, (c) or for correction of errors. Persons who have elected coverage hereunder and who have a payroll relationship with the State Auditor must authorize payroll deductions to pay their portion of the cost. Certain disabilitants, certain employees on leave without pay, COBRA participants and direct bill agencies remit fees directly to the Vendor. All eligibles and disabilitants must be allowed to enroll during Open Enrollment without regard to an active work requirement or pre-existing condition(s).

ARTICLE V - PLAN FINANCING AND BENEFIT ELECTIONS

5.01 Benefit Dollars

For each Plan Year, the Employer will determine the amount of Benefit Dollars which can be credited to the Account of each Participant, and shall inform each Participant in writing of the amount before the beginning of the Plan Year. The amount will consist of Salary Reduction Benefit Dollars which the Employer shall credit to the Account of each Participant who has elected to reduce the amount of his Compensation for the Plan Year. An election may only be made pursuant to a written agreement between the Participant and his Employer, which shall specify the amount of the reduction in Compensation, which is to be credited to the Account of the Participant.

5.02 Elections and Consents

The election required by Section 5.01 must be submitted to the Employer in the format required by your Employer during the Open Enrollment period.

5.03 Changes by the Employer

If the Employer determines the Plan may fail to satisfy any non-discrimination requirements imposed by the Code, the Employer shall take any action as it deems appropriate to assure compliance with such requirement, to include, without limitation, a modification of elections by Highly Compensated Participants with or without their permission.

5.04 Irrevocability of Election by the Participant During the Plan Year

Elections made under Section 5.01 of the Plan shall be irrevocable by the Participant during the Plan Year, except in the event of a change in family status. A change in family status as defined by the Employer for each benefit consistent with IRS guidelines will permit a change or revocation of an election during a Plan Year. Any new election under this Section 5.04 shall be effective at the time as the Employer shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Employer.

5.05 Automatic Termination of Election and Consent

Elections and consents made under this Plan shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan.

5.06 Forfeitures

Benefit Dollars which are credited to the Account of a Participant on the last day of the Plan Year will be forfeited by the Participant, unless otherwise provided in the grace period.

ARTICLE VI - OPTIONAL BENEFITS

6.01 Benefit Options

Each Plan Year, each Participant shall have the option to apply the Benefit Dollars credited to his Account in order to provide the following benefits.

- (a) Dependent Care Expense Reimbursement Program. To the extent a Participant elects, any or all of the Benefit Dollars credited to his Dependent Care Expense Reimbursement Account

shall be used for reimbursement of employment-related dependent care expenses incurred by the Participant.

- (b) Health Care Expense Reimbursement Program. To the extent a Participant elects, any or all of the Benefit Dollars credited to his Health Care Expense Reimbursement Account shall be used for reimbursement of health care expenses not covered by the Employer's health or dental benefit plan or any other plan or policy providing health and dental benefits to the Participant and his dependents.
- (c) Limited Scope Reimbursement Program. To the extent a Participant, who makes/receives tax favored contributions to a Code Section 223 HSA, elects, all of the Benefit Dollars credited to his Limited Scope Reimbursement Account shall be limited to reimbursement of specific health care expenses not covered by the Employer's health, dental, or vision plan or any other plan or policy providing health, dental, and vision benefits to the Participant and his dependents. The full scope of expenses eligible for reimbursement under the Limited Scope Reimbursement program is identified within the Health Care Expense Reimbursement Plan section.
- (d) Health Savings Accounts. To the extent Participants are enrolled in a High Deductible Health Plan (HDHP), also known as a Consumer Driven Health Plan (CDHP), and are not covered by any other health plan that is not a CDHP, they may elect to enroll in a Health Savings Account (HSA), which is an individual savings account that allows Participants to set aside money for current and future medical expenses. Contributions to a Participants HSA are made on a pre-tax basis and are not subject to "use it or lose it" provisions.

6.02 Cash

For any Plan Year, in lieu of any of the benefits described in Section 6.01, except for employer contributions to an HSA, a Participant may elect to receive in cash all of the amounts which are or could have been credited to his Account as Salary Reduction Benefit Dollars.

ARTICLE VII - PROHIBITED DISCRIMINATION

7.01 Cafeteria Plan Anti-Discrimination Rules

In accordance with Section 125 of the Code, the Plan shall not discriminate in favor of Highly Compensated Employees or highly compensated Participants.

7.02 Other Code Anti-Discrimination Rules

The benefits available under this Plan are, in all instances, provided by separate employee benefit plans for which the Code may impose specific non-discrimination requirements. Each benefit option as described in Article VI shall be governed by any applicable non-discrimination requirement imposed by the Code in order to avoid discrimination in favor of Highly Compensated Participants or highly compensated Employees.

ARTICLE VIII - ADMINISTRATION OF PLAN

8.01 Administration

"Contractor", as defined in the Agreement for Flexible Spending Account Plan Administration, is the plan administrator. The Plan administrator may delegate its powers and authority under the Plan and may designate any person or persons to exercise these powers and authority on its behalf.

In the delegation of powers and authority, the Plan administrator may limit the authority of the recipient of the delegated powers and the authority to redelegate those powers and authority to another person or persons.

8.02 Powers of Plan Administrator

The Plan administrator shall have all powers which are necessary to administer the Plan, including but not limited to the interpretation of the provisions of the Plan, the establishment of accounting methods for the Plan, the establishment of rules and the prescription of any forms necessary or desirable for the administration of the Plan.

8.03 Actions of Plan Administrator

All determinations, interpretations, rules and decisions of the Plan administrator shall be conclusive and binding upon all persons having or claiming to have an interest or right under the Plan.

8.04 Claims

Any claim which arises under any employee benefit plan (health, dental or vision) maintained by the Employer shall not be subject to review under this Plan. The Plan administrator's authority under Section 8.02 shall not extend to any matter as to which an administrator under any other employee benefit plan maintained by the Employer is empowered to make determinations and all claims will be processed in accordance with the claims procedures of that benefit plan.

8.05 Examination of Records

The Plan administrator will make available to each Participant any records under the Plan that pertain to him, for examination at reasonable times during normal business hours.

8.06 Reliance on Tables, etc

In administering the Plan, the Plan administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the above-referenced employees benefit plans, or by accountants, counsel or other experts employed or engaged by the Plan administrator.

8.07 Non-discriminatory Exercise of Authority

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a non-discriminatory manner. It shall be the principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan.

ARTICLE IX - AMENDMENT AND TERMINATION OF PLAN

The Employer reserves the right to amend or terminate the Plan in whole or in part at any time by a duly adopted resolution of the State Personnel Director and Director of the State Budget Agency.

ARTICLE X - MISCELLANEOUS PROVISIONS

10.01 Information to be Furnished

Participants shall provide the Employer and Plan Administrator with any information and evidence, and shall sign all documents, as may reasonably be requested from time to time for the purpose of the administration of the Plan.

10.02 Limitation of Rights

Nothing in this Plan nor any election made hereunder shall give a Participant or his beneficiary the right to any benefit payments under this Plan, a Participant's rights being limited to the right to elect the optional benefits described in Article VI. Coverage and the right to benefit payments are governed by the applicable employee benefit plan of the Employer. The establishment of this Plan shall not be construed to give any Employee a right to be continued in the employ of the Employer or as interfering with the right of the Employer to terminate the employment of any Employee at any time.

10.03 Governing Law

This Plan and all rights hereunder shall be governed by and construed according to the laws of the state of Indiana, except to the extent those laws are preempted by the laws of the United States of America.

HEALTH CARE EXPENSE REIMBURSEMENT PLAN

ARTICLE I - INTRODUCTION

1.01 The Employer has established this Health Care Expense Reimbursement Plan (the "Plan") to meet the needs of those of its Employees who are Participants in the Plan. The purpose of this Plan is to provide for the medical protection for certain Participants, their spouses and their dependents, in recognition of the fact that their health and their freedom from concern for their physical welfare are of great importance to the Employer.

The Plan will provide benefits only for certain items of medical and dental care expenses, except where noted otherwise, which are not covered by any other type of employee benefit plan or individual insurance. The Plan is intended to qualify as a self-insured medical reimbursement plan as defined in Section 105 of the Internal Revenue Code of 1986, as amended (the "Code").

1.02 The Plan has been adopted by execution of a copy of the accompanying Adoption Agreement. The provisions of the Adoption Agreement are hereby incorporated in and made a part of the Plan.

1.03 The provisions of this Plan are applicable only to those eligible persons who are Employees of the Employer on or after the Effective Date.

ARTICLE II - DEFINITIONS

2.01 "Adoption Agreement" means the written agreement, executed by the Employer, by which the Employer adopts, this Plan, and the provisions of which are incorporated in this Plan by reference.

2.02 "Anticipated Contributions" means the total amount of contributions the participant is expected to make during the plan year.

2.03 "Appeals Committee" means a committee of at least one (1) individual appointed by the Plan Administrator.

2.04 "Consumer Driven Health Plan" means a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Synonymous with "High Deductible Health Plan."

2.05 "Coverage Period" means a period of time during the Plan Year in which benefits are stable due to a regular contribution amount.

2.06 "Dependent" means the spouse of the Participant and a child of the Participant as defined in Code Section 152(f)(1) up to age 26.

2.07 "Effective Date" means the date specified by the Employer in the Adoption Agreement.

2.08 "Eligibility Requirement" means the requirement(s) for participation set forth in the Agreement for Flexible Spending Account Plan Administration.

- 2.09 "Employer" means the State of Indiana which adopts this Plan by executing an Adoption Agreement and any successor thereto which in writing assumes the obligations of the Employer.
- 2.10 "Employee" means any person who is employed by the Employer for purposes of the Federal Insurance Contributions Act.
- 2.11 "Limited Scope Reimbursement Option" means the Health Care FSA which provides qualified coverage and limited reimbursement for those also participating in a Health Savings Account (HSA). Reimbursement limitations under the Limited Scope Reimbursement Option are set out in 5.03.
- 2.12 "Participant" means any Employee who has satisfied the eligibility requirements under Article III of the Plan.
- 2.13 "Plan Administrator" means "Contractor", as defined in the Agreement for Flexible Spending Account Plan Administration.
- 2.14 "Plan Year" means the 12 month period designated by the Employer in the Agreement for Flexible Spending Account Plan Administration.
- 2.15 "Qualifying Expenses" means expenses that qualify under Code Section 213(d) that are not reimbursable by any other health plan. Expenses allowed under Code Section 213(d) include medical, dental and vision services for the treatment and cure of illness and accidental injuries as well as transportation that is primarily for, and essential to, medical care for the Participant or his Dependents. This term also includes over the counter drugs and medicines when prescribed by a physician to the extent the expense is not prohibited under any other Code provision or regulation.

ARTICLE III - ELIGIBILITY

- 3.01 The Employee who is eligible to participate on the first day of the month following the completion of the Eligibility Requirements specified by the Employer in the Adoption Agreement.
- 3.02 If the Employee elects to participate in the Plan and makes the required contributions, coverage shall begin on the first day of the month following the date of the election and shall continue until the earlier of the last day of the Plan Year or the date coverage ceases.
- 3.03 If a terminated Employee is rehired within 30 days of termination, the Employee must resume the same benefit election prior to termination. If a terminated Employee is rehired after 30 days of termination, the Employee must elect new benefits.
- 3.04 According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the expenses identified in 5.03 (the "Limited Scope Reimbursement Option"). Unless the IRS-qualified High Deductible Health Plan (HDHP), also known as a Consumer Driven Health Plan (CDHP), covered Health FSA

Participant positively elects otherwise during the Initial and/or Annual Enrollment Periods, eligible expenses under the Health FSA for Participants covered by an HDHP will default to the expenses under the Limited Scope Reimbursement Option as set out in 5.03.

ARTICLE IV - TERMINATION OF ELIGIBILITY

4.01 The eligibility of a Participant will cease upon the earlier of the following:

- (a) termination of employment;
- (b) termination of the Plan;
- (c) amendment to the Plan which terminates coverage of a classification of Employees to which the Participant belongs;
- (d) the Participant fails to make the required contributions;
- (e) the Participant fails to meet the Eligibility Requirements.

4.02 Benefit elections for a Participant who terminates employment during the Plan Year will stop at the time of termination.

ARTICLE V - BENEFITS

5.01 Not later than ninety (90) days following the date upon which the Participant submits appropriate claim information, the Plan Administrator shall reimburse the Participant up to the Anticipated Contribution for a given Coverage Period for qualifying expenses.

5.02 If the Participant fails to make the required contributions for any reason including termination, or changes the level of contributions as provided in Code Section 125, the Anticipated Contributions shall be recalculated based on the total contributions expected during the entire Plan Year. The result of the recalculation shall be the Anticipated Contribution, which applies from the first day of the initial Coverage Period through the last day of the Plan Year.

5.03 Under the Limited Scope Reimbursement Option, Participant reimbursements under this Health FSA will be limited to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213 (d)):

- (a) Services or treatments for dental care (excluding premiums)
- (b) Services or treatments for vision care (excluding premiums)
- (c) Services for preventive care. Preventive care is defined in accordance with applicable rules and regulations but is essentially limited to diagnostic procedures and services or treatment taken to prevent the onset of disease or condition that is imminently possible. This may include any prescription or over the counter drugs to the extent such drugs are taken by an eligible individual (i) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (ii) to prevent the recurrence of a condition from which the eligible individual has recovered or (iii) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.
- (d) Eligible medical expenses incurred after the "minimum deductible" has been satisfied. The applicable minimum deductible under this plan is conditioned on the Participant's family status. The minimum deductible is the minimum statutory deductible amount, as set forth

in Code Section 223(c)(2)(A)(i) (adjusted for inflation), applicable to the participants family status.

ARTICLE VI - PLAN ADMINISTRATOR

- 6.01 The Plan Administrator shall be named fiduciary of the Plan and shall have the authority to manage the operation and administration of the Plan and to adopt such rules and regulations consistent with the Plan as it shall deem appropriate to administer the Plan. All determinations by the Plan Administrator shall be conclusive and binding on all Participants, their spouses and dependents.
- 6.02 The Plan Administrator shall submit to each Participant receiving Benefits under the Plan during a Plan Year a statement of the amount of Benefits received by the Participant during that Plan Year. The statement shall be furnished to the Participant by the January 31st coinciding with or next following the end of the Plan Year.

ARTICLE VII - CLAIMS PROCEDURE

- 7.01 A Participant shall make a claim for Benefits by making a request in accordance with Article V. The grace period will extend for two months and fifteen days past the end of each plan year. The grace period applies to all participants in the cafeteria plan, except as limited under the Limited Scope Reimbursement Program. Expenses for qualified benefits that are incurred during the grace period will be paid or reimbursed first from benefits or contributions that remain unused at the end of the prior plan year. Any unused amounts from the prior plan year that are not used to reimburse expenses by the end of the grace period remain subject to the "use it or lose it" rule and must be forfeited.

All claims for benefits that are incurred during the plan year and during the grace period must be submitted no later than 90 days after the end of the grace period.

For those individuals participating in the employer's Consumer Driven Health Plan (CDHP), reimbursable expenses during the grace period applicable to the previous Flexible Benefits Plan year will be restricted to those expenses listed within the "Limited Scope Reimbursement" provision set out in 5.03.

- 7.02 If a claim is wholly or partially denied, notice of a decision, in accordance with Section 7.03, shall be furnished to the Participant within a reasonable period of time, not to exceed ninety (90) days after receipt of the claim by the Plan Administrator, unless special circumstances require an extension of time for processing the claim.

If an extension of time is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial ninety (90) day period. In no event shall the extension exceed a period of ninety (90) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date on which the Plan Administrator expects to render a decision.

- 7.03 The Plan Administrator shall, upon request, provide a Participant who is denied a claim for benefits written notice setting forth, in a manner calculated to be understood by the claimant, the following:

- (a) a specific reason or reasons for the denial;
- (b) specific reference to pertinent Plan provisions upon which the denial is based;
- (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why that material or information is necessary;
- (d) an explanation of the Plan's claim review procedure, as set forth below in Sections 7.04 and 7.05.

7.04 The purpose of the review procedure set forth in this Section and Section 7.05 is to provide a procedure by which a Participant, under the Plan, may have reasonable opportunity to appeal a denial of a claim to the Appeals Committee for a full and fair review. To accomplish that purpose, the Participant, or his duly authorized representative may:

- (a) request review upon written application to the named fiduciary;
- (b) review pertinent Plan documents; and
- (c) submit issues and comments in writing.

A Participant or his duly authorized representative shall request a review by filing a written application for review with the Appeals Committee at any time within sixty (60) days after receipt of written notice of the denial of his claim.

7.05 Decision on review of a denied claim shall be made in the following manner:

- (a) The decision on review shall be made by the Appeals Committee, which may, in its discretion, hold a hearing on the denied claim; the Appeals Committee shall make its decision not later than sixty (60) days after the Plan Administrator receives the request for review, unless special circumstances require extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If an extension of time for review is required, written notice of the extension shall be furnished to the Participant prior to the commencement of the extension.
- (b) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the Participant, and specific references to the pertinent Plan provisions on which the decision is based.
- (c) In the event that the decision on review is not furnished within the time period set forth in Section 7.05(a), the claim shall be deemed denied on review.

7.06 If a dispute arises with respect to any matter under this Plan, the Plan Administrator may refrain from taking any other or further action in connection with the matter involved in the controversy until the dispute has been resolved.

ARTICLE VIII - FUNDING

Contributions required to pay benefits under this Plan shall consist of contributions by the Participants as selected by the Employer under the Employer's flexible benefit plan.

ARTICLE IX - AMENDMENT AND TERMINATION

This Plan may be amended, suspended or terminated at any time by State Personnel Director and Director of the State Budget Agency.

ARTICLE X - MISCELLANEOUS

- 10.01 Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural, and vice versa.
- 10.02 This Plan shall not be deemed to constitute a contract between the Employer and any Participant or Employee or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect the discharge shall have upon him as a Participant of this Plan.
- 10.03 This Plan shall be construed and enforced according to the laws of the state of Indiana, except to the extent those laws are preempted by the laws of the United States of America.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

ARTICLE I - INTRODUCTION

- 1.01 The Employer has established this Dependent Care Assistance Plan (the "Plan") to meet the needs of those employees who are Participants in the Plan. The purpose of this Plan is to reimburse Eligible Employees for the cost of dependent care assistance. The Plan is intended to qualify as a plan providing dependent care assistance within the meaning of Section 129 of the Internal Revenue Code of 1986, as amended, (the "Code") and that certain of the benefits provided under the Plan be eligible for exclusion from the income of Employees under Code Section 129.
- 1.02 The Plan has been adopted by execution of the accompanying Adoption Agreement. The provisions of the Adoption Agreement are hereby incorporated in and made a part of the Plan.
- 1.03 The provisions of this Plan are applicable only to those eligible persons who are Employees of the Employer on or after the Effective Date.

ARTICLE II - DEFINITIONS

- 2.01 "Adoption Agreement" means the written agreement, executed by the Employer, by which the Employer adopts this Plan, and the provisions of which are incorporated in this Plan by reference.
- 2.02 "Appeals Committee" means a committee of at least one (1) individual appointed by the Plan Administrator.
- 2.03 "Benefits" means the amounts paid to Participants under the Plan as reimbursements for Eligible Employment Related Expenses incurred by a Participant.
- 2.04 "Dependent" means any individual who is a dependent of a Participant within the meaning of Code Section 152(a).
- 2.05 "Earned Income" means all income derived from wages, salaries, tips, self-employment and other employee compensation but does not include any amounts received (i) under the Plan or any other dependent care assistance program under Code Section 129; or (ii) as a pension or annuity.
- 2.06 "Effective Date" means the date specified by the Employer in the Adoption Agreement.
- 2.07 "Eligibility Requirement" means the requirement(s) for participation set forth in the Adoption Agreement.
- 2.08 "Eligible Employee" means any individual employed by the Employer for purposes of the Federal Insurance Contributions Act.
- 2.09 "Eligible Employment Related Expenses" means all Employment Related Expenses incurred by a Participant which are paid to a person who is not:

- (a) a Dependent of the Participant;
- (b) the Participant's Spouse; or
- (c) a child of the Participant under the age of 19.

2.10 "Employer" means the State of Indiana which adopts this Plan by executing an Adoption Agreement and any successor thereto which in writing assumes the obligations of the Employer.

2.11 "Employment Related Expenses" means expenses incurred for Qualifying Services or for the cost of sending a child of the Participant to a Qualifying Day Care Center.

2.12 "Participant" means any Employee who has satisfied the eligibility requirements under Article III of the Plan.

2.13 "Plan Administrator" means "Contractor", as defined in the Agreement for Flexible Spending Account Plan Administration.

2.14 "Plan Year" means the 12 month period designated by the Employer in the Adoption Agreement.

2.15 "Qualifying Day Care Center" means:

- (a) a day care center which complies with all applicable laws and regulations;
- (b) provides care for more than six individuals, other than individuals who reside at the day care center; and
- (c) receives a fee payment or grant for providing Qualifying Services for the individuals.

2.16 "Qualifying Individual" means:

- (a) a Dependent of a Participant who is under the age of 13;
- (b) a Dependent of a Participant who is physically or mentally incapable of caring for himself; or
- (c) the Spouse of a Participant, if he is physically or mentally incapable of taking care of himself.

2.17 "Qualifying Services" mean Services performed:

- (a) in the home of the Participant; or
- (b) outside the home of the Participant for the care of a Dependent who is under the age of 13, or for the care of a Qualifying Individual other than a Dependent under the age of 13, who regularly spends at least eight (8) hours a day in the Participant's household.

2.18 "Services" means the services performed to enable a Participant or Spouse to remain gainfully employed and which are related to the care of a Qualifying Individual.

2.19 "Spouse" means the spouse of a Participant but shall not include an individual separated or divorced from a Participant.

2.20 "Student" means an individual who, during each of five calendar months during a Plan Year, is a full-time student at an educational institution.

ARTICLE III - ELIGIBILITY

- 3.01 The Employee may elect to participate in the Plan on the first day of the month following the completion of the Eligibility Requirements specified by the Employer in the Adoption Agreement.
- 3.02 If the Employee elects to participate in the Plan and makes the required contributions, coverage shall begin on the first day of the month following the date of the election and shall continue until the earlier of the last day of the Plan Year or the date coverage ceases.
- 3.03 If a terminated Employee is rehired within 30 days of termination, the Employee must resume the same benefit election prior to termination. If a terminated Employee is rehired after 30 days of termination, the Employee must elect new benefits.

ARTICLE IV - TERMINATION OF ELIGIBILITY

- 4.01 The eligibility of a Participant will cease upon the earlier of the following:
- (a) termination of employment;
 - (b) termination of the Plan;
 - (c) amendment to the Plan which terminates coverage of a classification of Employees to which the Participant belongs;
 - (d) the Participant fails to make the required contributions;
 - (e) the Participant fails to meet the Eligibility Requirements.
- 4.02 Benefit elections for a Participant who terminates employment during the Plan Year will stop at the time of termination.

ARTICLE V - BENEFITS

Each Participant in the Plan shall be eligible to receive Benefits under the Plan for all Eligible Employment Related Expenses incurred by the Participant after he became a Participant in the Plan, subject however to the limitations of Article VI.

ARTICLE VI - CLAIM FOR BENEFITS

- 6.01 Each Participant who desires to receive a Benefit under the Plan for Eligible Employment Related Expenses incurred for Qualifying Services shall, upon request, submit to the Plan Administrator a written statement containing the following information:
- (a) name of the Dependent for whom the Qualifying Services are to be performed;
 - (b) the nature of the Qualifying Services performed for the Participant, the cost for which he wishes to be reimbursed;
 - (c) the relationship, if any, of the person performing the Qualifying Services to the Participant;
 - (d) if the Qualifying Services are being performed by a child of the Participant, the age of that child;
 - (e) a statement as to where the Qualifying Services will be performed;

- (f) if the Qualifying Services are being performed in a day care center, a statement that (a) the day care center complies with all applicable laws and regulations; (b) the day care center provides care for more than six individuals (other than individuals residing at the center); and (c) the amount of compensation paid to the center;
- (g) if the Participant is married, a statement of (a) the Spouse's compensation if he is employed, or (b) if the Participant's Spouse is not employed, a statement that (1) he is incapacitated or (2) he is a full-time student attending an educational institution and the months during the year which he will attend the educational institution;
- (h) the name, address, and the Federal Tax Identification Number or Social Security Number of the individual or organization providing the care. The Federal Tax Identification Number or Social Security Number is not required if the individual or organization is tax-exempt.

6.02 If the Participant is eligible to receive Benefits under the Plan, he shall submit a statement to the Plan Administrator within ninety (90) days after the end of the plan year stating the amount of Eligible Employment Related Expenses incurred by the Participant. Within thirty (30) days of receiving the statement, the Plan Administrator shall pay the Participant the Benefits to which he is entitled under the Plan.

ARTICLE VII - LIMITATIONS ON BENEFITS

7.01 A Participant may not receive Benefits for Eligible Employment Related Expenses incurred for any month in excess of his Earned Income for that month. If the Participant is married, he may not receive benefits for any month in excess of the lesser of:

- (a) his Earned Income for the month; or
- (b) the Earned Income of his Spouse for that month.

7.02 For purposes of Section 7.01, a Spouse who is not employed during any month in which the Participant incurs Eligible Employment Related Expenses, and is either incapacitated or a Student, shall be deemed to have Earned Income for that month of:

- (a) \$200, if there is one Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses; or
- (b) \$400, if there is more than one Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses.

7.03 A Participant may not receive Benefits for Eligible Employment Related Expenses for any calendar year in excess of \$5,000.00. A married Participant who files a separate individual tax return may not receive Benefits for Eligible Employment Related Expenses for any calendar year in excess of \$2,500.00.

ARTICLE VIII - FUNDING

Contributions required to pay Benefits under this Plan shall consist of contributions by the Participant under the Employer's flexible benefit plan.

ARTICLE IX - PLAN ADMINISTRATOR

- 9.01 The Plan Administrator shall be the named fiduciary of the Plan and shall have the authority to manage the operation and administration of the Plan and to adopt such rules and regulations consistent with the Plan as it shall deem appropriate to administer the Plan. All determinations by the Plan Administrator shall be binding upon Participants, their spouses and dependents.
- 9.02 The Plan Administrator shall submit to each Participant receiving Benefits under the Plan during a Plan Year a statement of the amount of Benefits received by the Participant during that Plan Year. The statement shall be furnished to the Participant by the January 31st coinciding with or next following the end of the Plan Year.

ARTICLE X - CLAIMS PROCEDURE

- 10.01 A Participant shall make a claim for Benefits by making a request in accordance with Article VI. The grace period will extend for two months and fifteen days past the end of each plan year. The grace period applies to all participants in the cafeteria plan. Expenses for qualified benefits that are incurred during the grace period will be paid or reimbursed first from benefits or contributions that remain unused at the end of the prior plan year. Any unused amounts from the prior plan year that are not used to reimburse expenses by the end of the grace period remain subject to the "use it or lose it" rule and must be forfeited.

All claims for benefits that are incurred during the plan year and during the grace period must be submitted no later than 90 days after the end of the grace period.

- 10.02 If a claim is wholly or partially denied, notice of a decision, in accordance with Section 10.03, shall be furnished to the Participant within a reasonable period of time, not to exceed ninety (90) days after receipt of the claim by the Plan Administrator, unless special circumstances require an extension of time for processing the claim. If an extension of time is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial ninety (90) day period. In no event shall the extension exceed a period of ninety (90) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date on which the Plan Administrator expects to render a decision.
- 10.03 The Plan Administrator shall, upon request, provide a Participant who is denied a claim for benefits written notice setting forth, in a manner calculated to be understood by the claimant, the following:
- (a) a specific reason or reasons for the denial;
 - (b) specific reference to pertinent Plan provisions upon which the denial is based;
 - (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why that material or information is necessary;
 - (d) an explanation of the Plan's claim review procedure, as set forth below in Sections 10.04 and 10.05.
- 10.04 The purpose of the review procedure set forth in this Section and Section 10.05 is to provide a procedure by which a Participant, under the Plan, may have reasonable opportunity to appeal a

denial of a claim to the Appeals Committee for a full and fair review. To accomplish that purpose, the Participant, or his duly authorized representative may:

- (a) request review upon written application to the named fiduciary;
- (b) review pertinent Plan documents; and
- (c) submit issues and comments in writing.

A Participant or his duly authorized representative shall request a review by filing a written application for review with the Appeals Committee at any time within sixty (60) days after receipt of written notice of the denial of the claim.

10.05 Decision on review of a denied claim shall be made in the following manner:

- (a) The decision on review shall be made by the Appeals Committee, which may, at its discretion, hold a hearing on the denied claim. The Appeals Committee shall make its decision not later than sixty (60) days after the Plan Administrator receives the request for review, unless special circumstances require extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If an extension of time for review is required, written notice of the extension shall be furnished to the Participant prior to the commencement of the extension.
- (b) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the Participant, and specific references to the pertinent Plan provisions on which the decision is based.
- (c) In the event that the decision on review is not furnished within the time period set forth in Section 10.05(a), the claim shall be deemed denied on review.

10.06 If a dispute arises with respect to any matter under this Plan, the Plan Administrator may refrain from taking any other or further action in connection with the matter involved in the controversy until the dispute has been resolved.

ARTICLE XI - AMENDMENT AND TERMINATION

This Plan may be amended, suspended or terminated at any time by State Personnel Director and Director of the State Budget Agency.

ARTICLE XII - MISCELLANEOUS

12.01 Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural, and vice versa.

12.02 This Plan shall not be deemed to constitute a contract between the Employer and any Participant or Employee or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect the discharge shall have upon him as a Participant of this Plan.

12.03 This Plan shall be construed and enforced according to the laws of the state of Indiana, except to the extent those laws are preempted by the laws of the United States of America.

HEALTH SAVINGS ACCOUNT

ARTICLE I – INTRODUCTION

- 1.01 The Health Savings Account (HSA) is a tax-advantaged personal savings account that eligible employees may use to pay for qualified medical expenses, for the employee and eligible dependents, and has been established for those employees who meet eligibility requirements. Unused funds that are retained in this account accumulate from year to year; there is no “use it or lose it” provision.
- 1.02 The HSA will be considered a qualified benefit under the Employer’s Flexible Benefits Plan.
- 1.03 The account has been adopted by execution of a copy of the accompanying Adoption Agreement. The provisions of the Adoption Agreement are hereby incorporated in and made a part of the Plan.
- 1.04 The provisions of this Plan are applicable only to those eligible persons who are Employees of the Employer on or after the Effective Date.

ARTICLE II – DEFINITIONS

- 2.01 "Adoption Agreement" means the written agreement, executed by the Employer, by which the Employer adopts this Plan, and the provisions of which are incorporated in this Plan by reference.
- 2.02 "Appeals Committee" means a committee of at least one (1) individual appointed by the Plan Administrator.
- 2.03 "Dependent" means any individual who is a dependent of a Participant within the meaning of Code Section 152(a).
- 2.04 "Effective Date" means the date specified by the Employer in the Adoption Agreement.
- 2.05 "Eligibility Requirement" means the requirement(s) for participation set forth in the Agreement for Flexible Spending Account Plan Administration.
- 2.06 "Eligible Employee" means any individual employed by the Employer for purposes of the Federal Insurance Contributions Act.
- 2.07 "Employer" means the State of Indiana which adopts this Plan by executing an Adoption Agreement and any successor thereto which in writing assumes the obligations of the Employer.
- 2.08 "Participant" means any Employee who has satisfied the eligibility requirements under Article III of the Plan.
- 2.09 "Plan Administrator" means the financial institution to which the State makes direct deposits of HSA funds.

ARTICLE III – ELIGIBILITY

3.01 High Deductible Health Plan (HDHP) Participation

In order to participate in an HSA, an Eligible Employee must be a participant in a qualified HDHP and may not be covered under any other health plan that is not a qualified HDHP. A HDHP is also referred to as a Consumer Driven Health Plan (CDHP).

3.02 HSA Benefits

An Eligible Employee may elect to participate in the HSA by electing to pay the contributions on a pre-tax basis. The tax treatment of the HSA is governed by Code Section 223. The Employee's HSA must be established and maintained outside the health plan by a trustee/custodian where the Employer can forward contributions to be deposited.

ARTICLE IV – TERMINATION OF ELIGIBILITY

The ability for a Participant to make pre-tax contributions to the HSA through this Flexible Benefits Plan will end when a Participant ceases to meet the eligibility requirements, becomes covered by a health plan that is not a qualified HDHP, or terminates employment.

ARTICLE V – BENEFITS

5.01 Maximum Contributions per Year for Employee Only Coverage and Family Coverage are defined by Code Section 223(b)(2), and may be adjusted for cost of living through Section 223(g). For families with multiple per-person deductibles, you cannot deposit more into an HSA than the maximum amount allowed for family coverage. Eligible employees can front load or fully fund your HSA, provided you do not exceed the maximum contribution amount.

5.02 Deposits to an HSA must be made in cash or through a rollover from a Flexible Spending Account, Health Reimbursement Arrangement, Individual Retirement Account, or another HSA.

5.03 HSA's provide coverage for a wide range of medical expenses, including dental and vision expenses, as covered in the IRS Publication 502 and IRC §213(d).

5.04 Tax penalties will be incurred on withdrawals from an HSA that are not used for qualified medical expenses, in accordance with HR 3590 §9004(a).

ARTICLE VI – PLAN ADMINISTRATOR

HSA Account and Trust/Custodial Agreement— The HSA is an individual trust or custodial account established and maintained by the trustee/custodian outside the health plan. The HSA trustee/custodian may be chosen by the Participant. The Employer may, however, limit the number of HSA providers to whom it will send contributions. The Employer has no authority or control over the contributions deposited in a HSA.

ARTICLE VII – CLAIMS PROCEDURE

7.01 Participation in a General Purpose Health Care FSA Governed by a Grace Period

Participants in a General Purpose Health Care FSA may not participate in the HSA. If, however, at the end of the General Purpose Health Care FSA Plan Year the Participant's General Purpose Health Care FSA has a zero balance, an HDHP Participant would be eligible to participate in the HSA (provided the Participant no longer participates in the General Purpose Health Care FSA and either participates in no Health Care FSA or participates in a Limited Purpose Health Care FSA).

If a Participant participates in a General Purpose Health Care FSA at the end of the Plan year and still has a balance in his or her General Purpose Health Care FSA, he or she may not participate in the HSA until the first of the month following the end of the Grace Period (provided he or she no longer participates in the General Purpose Health Care FSA).

7.02 Rollover of Unused Funds from an Existing Health Care FSA

Participants have a one-time opportunity to rollover unused funds from an existing Health Care FSA into their HSA. Only one such distribution may be made to a Participant per Health Care FSA. The amount that can be distributed from a Health Care FSA and contributed to a HSA may not exceed an amount equal to the lesser of: 1) the balance in the Health Care FSA as of September 21, 2006, or 2) the balance in the Health Care FSA as of the date of distribution. Amounts contributed to an HSA under this provision are excludable from gross income and wages for employment tax purposes and are not taken into account in applying the maximum deduction limitation for other HSA contributions.

The Participant must be HSA eligible in the month in which the qualified HSA distribution is contributed to his or her HSA and must remain HSA eligible for the subsequent "testing period" which is 12 months after the close of the month of the contribution, or pay tax on the contribution and a 20% penalty tax (except if the Participant dies or becomes disabled).

Rollover of unused funds from the Health Care FSA to the HSA must be elected by December 31 of the Plan Year and must be distributed by March 15 of the following Plan Year. The Health Care FSA makes no reimbursements to the rollover Participant after the last day of the Plan Year. Distributions must be made directly to the HSA by the Employer before January 1, 2012.

7.03 Termination – The ability for a Participant to make pre-tax contributions to the HSA through this Flexible Benefits Plan will end when a Participant ceases to meet the eligibility requirements, becomes covered by a health plan that is not a qualified HDHP, or terminates employment.

ARTICLE VIII – FUNDING

8.01 Contributions for Cost of Coverage for HSA – The annual contribution for a Participant's HSA is equal to the annual benefit amount elected by the Participant. The amount elected may not exceed the statutory maximum amount for HSA contributions for the calendar year in which the contribution is made. The combination of the Employer's contribution (see provision (e) below) and the Participant's contribution may not exceed the statutory maximum.

Additional catch-up contribution amounts for Participants age 55 or older can be found in Code Section 223(b)(3)(B).

8.02 Employer Contributions for Cost of Coverage for HSA – The amount of the Employer contribution may change annually. The Participant must participate in the Employer's HDHP to receive the

Employer's contribution. Contributions by the Employer may be prorated based on the date a Participant becomes a Participant in the HSA.

8.03 Changes to the HSA Account – The Employee's election can be increased (up to the maximum amount), decreased, or revoked prospectively at any time during the Plan Year.

ARTICLE IX – AMENDMENT AND TERMINATION

This Plan may be amended, suspended or terminated at any time by State Personnel Director and Director of the State Budget Agency.

ARTICLE X – MISCELLANEOUS

10.01 Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural, and vice versa.

10.02 This Plan shall not be deemed to constitute a contract between the Employer and any Participant or Employee or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect the discharge shall have upon him as a Participant of this Plan.

10.03 This Plan shall be construed and enforced according to the laws of the state of Indiana, except to the extent those laws are preempted by the laws of the United States of America.