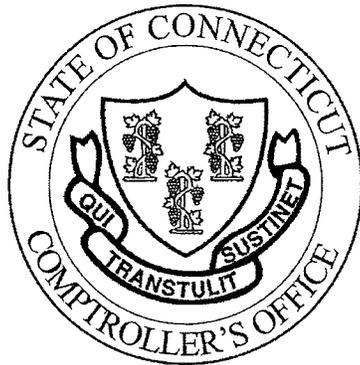


**STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
MEDICAL FLEXIBLE SPENDING ACCOUNT**



PLAN DOCUMENT

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**STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
MEDICAL FLEXIBLE SPENDING ACCOUNT**

INTRODUCTION

The Office of the State Comptroller, on behalf of the State of Connecticut, (“the Employer”), a governmental entity under the Internal Revenue Code of 1986, pursuant to Connecticut General Statute Section 5-264d, established a Medical Flexible Spending Account Plan (“the Plan”), effective January 1, 2011. The Plan is hereby amended and restated as of January 1, 2013.

It is the intention of the Employer that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986 (“the Code”), as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended. The purpose of the Plan is to allow participating employees to use pre-tax dollars to receive reimbursement for eligible out-of-pocket medical and dental care expenses incurred by them, their spouse, dependents or adult children who are not otherwise covered by a group health plan sponsored by the Employer or other employing entity.

**ARTICLE I
DEFINITIONS**

1.1 **"Administrator"** means the corporation appointed by the Employer to carry out the administration of the Plan. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** means the benefit available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefits as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Capital Expenditure"** means special equipment installed in a home or improvements if the main purpose is medical care for you, your spouse or your dependent. The cost of permanent improvements that increase the value of your property may be partly included

as a medical expense. The cost of the improvement is reduced by the increase in the value of your property. The difference is a medical expense.

1.6 **"Capital Expenditure Form"** means the form used to justify a Capital Expenditure.

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

1.8 **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1986.

1.9 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.10 **"Dependent"** means any individual who qualifies as an Employee's dependent under Code Section 152 (as modified by Code Section 105(b)).

1.11 **"Effective Date"** means January 1, 2011.

1.12 **"Election Period"**, also known as "Open Enrollment," means the period established by the Administrator immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.13 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

Any Employee who is a "part-time" Employee is not eligible to participate in this Plan. A "part-time" Employee is defined as any Employee who works, or is expected to work on a regular basis, less than 0.5 full time equivalent ("FTE"). Per diem, sessional, temporary or seasonal workers, adjunct faculty and graduate assistants are not eligible to participate in the Plan.

Former employees and rehired retirees are not eligible to participate in the Plan.

1.14 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.15 **"Employer"** means State of Connecticut. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.16 **"Incurred or Incurred Date"** means the date when the medical or dental services giving rise to medical or dental expense are performed and not on the date that such services are billed by the service provider or paid by the participant.

1.17 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the IRS regulations thereunder.

1.18 **"Letter of Medical Necessity Form"** means the form signed by the treating physician to obtain reimbursement for an incurred expense for a service or product that may have both a medical and a personal or general purpose.

1.19 **"Medical and Dental Expenses"** means qualified medical and dental expenses under Internal Revenue Code Sections 105 and 213 not otherwise covered under a group health plan. Medical and Dental Expenses must be Incurred during the Plan Year by the Participant, the Spouse or the Dependent. Qualified expenses do not include any premiums paid for health insurance coverage for the Participant, spouse, or any dependent or adult. Expenses Incurred for the purchase of medicines and drugs that do not require a physician's prescription cannot be a qualified expense unless the medicines and drugs were obtained for the treatment, prevention or diagnosis of a specific medical condition by the Participant, Spouse or Dependent and are accompanied by a Letter of Medical Necessity Form.

1.20 **"Over-The-Counter (OTC) Drugs"** means products that are legally purchased without a prescription and are generally accepted as falling in the category of medicine and drugs. OTC drugs do not include toiletries or other similar preparations, cosmetics or dietary supplements that are merely beneficial to the general health of the individual. For purposes of the Plan, the Administrator has the sole discretion regarding additional restrictions on the type or amount of products that qualify as OTC drugs. A Letter of Medical Necessity Form must accompany the Claim Form in order for the OTC drug expense to be considered for reimbursement.

1.21 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.22 **"Plan"** means this instrument, including all amendments thereto.

1.23 **"Plan Year"** means the 12-month period beginning January 1st and ending December 31st. The Plan Year shall be the coverage period for the Benefits provided under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.24 **"Pre-Paid Benefits Card"** means a special purpose debit card that is loaded with a Participant's election amount at the beginning of the Plan Year plus any carryover amounts from the prior Plan Year and may be used to pay for eligible Medical and Dental Care Expenses. When the card is used to pay for eligible expenses, funds are automatically withdrawn from the Participant's account balance.

1.25 **"Qualified Beneficiary"** means an individual who is the employee's Spouse, child who is under the age of 27 years, or other tax dependent of the Participant under Code Section 152 and for whom a Participant is entitled to seek reimbursement for incurred eligible expenses under the Plan.

1.26 **"Qualifying Event"** means an event that gives rise to eligibility for COBRA benefits, including: For Participants, termination of employment for reasons other than gross misconduct or reduction in hours such that he or she is no longer working 0.5 FTE; for Spouses, the death of the Participant, the termination of the employee's employment for any reason other than gross misconduct, reduction in hours such that the Participant is no longer working 0.5 FTE, divorce or legal separation from the Participant; for children loss of Qualified Beneficiary status under the Plan, termination of the Participant's employment for any reason other than gross conduct, reduction in the Participant's hours such that the employee is no longer 0.5 FTE, divorce or legal separation of the Participant.

1.27 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to the account established under the Plan under Article V.

1.28 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant. For purposes of the Plan, the Salary Redirection Agreement is called the "Enrollment/Change Form" (the Form).

1.29 **"Spouse"** means the legally married husband or wife of a Participant, but does not include an individual who is legally separated from a Participant under a court decree of legal separation.

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder within 31 days of commencing employment or within 31 days of returning from an unpaid leave of absence if not previously enrolled in the Plan for the current Plan Year.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the date when his completed application to participate in the Plan has been accepted by the Administrator in accordance with Section 2.3.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete the Enrollment/Change Form and file it with the Administrator. Such election will be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof. An employee who is on an unpaid leave of absence is not eligible to enroll in the Plan during the Election Period and will be entitled to enroll within 31 days of returning to work provided he or she otherwise qualifies as an Eligible Employee.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.6;
- (b) **Change in employment status.** The end of the Plan Year during which the Participant became a limited Participant due to a change in employment status pursuant to Section 2.5;
- (c) **Death.** The Participant's death, subject to the provisions of Section 2.8; or
- (d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 9.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made, unless he or she is eligible for and has elected COBRA continuation coverage pursuant to Section 2.7. Any balances in the limited Participant's Medical Flexible Spending Account as of the date of the employment status change may be used for eligible Medical and Dental Expenses incurred prior to the date of the status change and submitted for reimbursement within 90 days after the date of the status change. All balances remaining in the limited Participant's Medical Flexible Spending Account after the 90-day run-out period will be forfeited to the Employer as set forth in Section 6.9 and will not be eligible for carryover pursuant to Section 6.8. If the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he or she otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and made an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Plan shall cease and no further Salary Redirection contributions shall be made, unless he or she is eligible for and has elected COBRA continuation coverage pursuant to Section 2.7. Any balances in the terminated Participant's Medical Flexible Spending Account as of the date of termination may be used for any eligible Medical and Dental Expenses incurred prior to the date of termination and submitted for reimbursement within 90 days after the date of termination. All balances remaining in the terminated Participant's Medical Flexible Spending Account after the 90-day run-out period will be forfeited to the Employer as set forth in Section 6.9 and will not be eligible for carryover pursuant to Section 6.8.

2.7 CONTINUATION OF MEDICAL FSA COVERAGE

Pursuant to COBRA, the Participant and Qualified Beneficiaries may be eligible to continue participation in the Plan, following a Qualifying Event, such as the death of the Participant, the divorce or legal separation of the Participant from his or her spouse, a loss of dependent status, or the Participant's termination of employment (other than for gross misconduct) or change of employment status that renders him or her ineligible for further participation. If there is a positive balance in the Participant's MEDFLEX account at the time of the Qualifying Event (taking into account all claims submitted before the date of the event), the Participant or a Qualifying Beneficiary, may be permitted to continue participation in the Plan for the remainder of the Plan Year, unless the maximum benefit available under the Plan for the remainder of the Plan Year is not more than the maximum benefit the Plan could require as payment for the remainder of the year. The Participant or Qualifying Beneficiary will be eligible to elect the full amount elected by the Participant minus any claims incurred for that individual.

Continuation in the FSA after a Qualifying Event must be elected within 60 days from the date of the COBRA notice provided to the Participant or Qualifying Beneficiary. In no event can the total amount of the funds available under the COBRA FSA exceed the amount of the annual election amount. Continuation of participation in MEDFLEX requires that an initial contribution be made to the Plan within 45 days of the election to participate in the COBRA FSA. Thereafter, the COBRA contribution shall be one-twelfth ($1/12^{\text{th}}$) of the elected amount, plus an additional two percent (2%) administrative fee, payable to Progressive Benefit Services, FBO State of Connecticut MEDFLEX Program. All contributions to the COBRA FSA must be paid on an after-tax basis. COBRA Medical FSA coverage will terminate no later than the end of the Plan Year during which the Qualifying Event occurs. Amounts remaining in a Participant's or Qualified Beneficiary's account at the end of the Plan Year are subject to the Forfeiture provision pursuant to Section 6.9 hereof and are not eligible for carryover to a subsequent Plan Year.

2.8 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's surviving spouse or dependent(s) may submit claims for expenses or benefits for the remainder of the Plan Year or until the funds in the Participant's Medical Flexible Spending Account are exhausted, whichever first occurs. In no event may reimbursements be paid to someone who is not a surviving spouse or eligible dependent.

**ARTICLE III
CONTRIBUTIONS TO THE PLAN**

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections that a Participant has elected hereunder. The Employer shall allow each Participant to agree to reduce his pay during the Plan Year by the amount elected in the Salary Redirection Agreement. The Salary Redirection shall be applicable for the entire Plan Year. The amount of such Salary Redirection shall be specified in the Form and may be subject to annual minimum or maximum election amounts, as determined by the Administrator. For any given Plan Year the minimum annual election amount is Five Hundred Twenty Dollars (\$520), and the maximum annual election amount is Twenty-Five Hundred Dollars (\$2500). The maximum and minimum Salary Redirection limits are not affected by amounts carried over from a prior Plan Year pursuant to Section 6.8. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be allocated to the Medical Flexible Spending Account pursuant to the Participants' election under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial election pursuant to Section 5.1) and before the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the IRS. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. In the event that contributions are missed for any reason, including processing error or unpaid leave, the remainder of the Participant's election amount will be divided equally over the remaining calendar year pay periods to ensure contribution of the annual election amount. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld shall be credited to the Medical Flexible Spending Account.

3.3 REFUND OF POST-TERMINATION CONTRIBUTIONS

Any contributions made to a Participant's Medical Flexible Spending Account after the date of a Participant's termination of employment shall be promptly refunded.

3.4 EFFECT OF UNPAID LEAVE OF ABSENCE

A Participant may either continue or suspend participation in the Plan during an unpaid leave of absence. Such election must be made prior to commencing unpaid leave. To continue participation during unpaid leave, the Participant must pay his or her contributions directly to the Plan Administrator on a post-tax basis. The Participant will be able to receive reimbursement for eligible claims incurred during the unpaid leave.

If participation is suspended during unpaid leave the Participant will not be eligible to obtain reimbursement for claims incurred during the leave of absence. Upon return to employment during the same plan year, the Participant will be reinstated for the remainder of the Plan Year in the original election amount, and his or her election amount (1) will be divided equally over the remaining calendar year pay periods [Example A], unless (2) within 31 days from returning to work the Participant elects (and is eligible) to reduce his or her election amount by the contributions missed during the unpaid leave. [See Example B] A Participant who returns to leave with an “overspent” account is not entitled to reduce his or her election if the resulting salary reductions for the remainder of the Plan Year (together with any carryover amount) would be insufficient to cover the amount Plan Year benefits already received by the Participant. [See Example C.]

Examples A-C use the same basic information: A Participant on a 24-pay (semi-monthly) cycle elected to contribute \$1200 for the Plan Year; her deduction is \$50 per pay period. In April she commenced unpaid leave and suspended her participation. Year-to-date deductions are \$300. During her 3-month leave she misses contributions of \$100 per month.

Example A – Before her leave the Participant received reimbursements of \$100. She returns from unpaid leave in July and is automatically reinstated for the remainder of the Plan Year in the original election amount; her remaining election amount is divided equally over the remaining calendar year’s pay periods as follows:

\$1200	Original election amount
(\$300)	Contributions paid between Jan. 1-Apr.1
\$ 900	Remaining election amount to be paid between July-Dec.
÷12	Remaining pay periods in year=\$75.00 per pay period

Participant has \$1100 in remaining benefits for the Plan Year but cannot submit be reimbursed for claims incurred during the unpaid leave.

Example B – Same facts as Example A, except that the Participant elects to reduce her election amount by the \$300 in contributions missed during unpaid leave:

\$1200	Original election amount
(\$300)	Contributions paid between Jan. 1-Mar.31
\$ 900	Remaining Plan Year payments at time of leave
(\$300)	Reduction in election for missed contrib. (Apr.1-July 1)
\$ 600	Balance of salary reduction amounts to be paid between July-Dec.
÷12	Remaining pay periods in year=\$50.00 per pay period

Participant has \$800 in remaining benefits [\$1200 (original amount) less \$100 (reimbursement received) less \$300 (contributions missed)]. She cannot submit claims incurred during the unpaid leave for reimbursement.

Example C-- Same facts, except that the Participant received Plan Year reimbursements of \$1100 before starting unpaid leave. When she returns she asks to reduce her Plan Year election by the \$300 in missed contributions. Because reduction of her annual election to \$900 would cause her account to be "overspent" by \$200 she is cannot reduce her election if the total salary reductions would be less than Plan Year benefits already received. She is permitted to reduce her annual election amount by \$100. She has no remaining benefits for the Plan Year. Her contributions are calculated as follows:

\$1200	Original election amount
(\$300)	Contributions paid between Jan. 1-Apr.1
\$ 900	Remaining election amount (before leave)
(\$100)	Reduction in election by missed contrib. (one month only)
\$ 800	Balance of election amount to be paid between July-Dec.
÷12	Remaining pay periods in year=\$66.67 per pay period

3.5 EFFECT OF PAID LEAVE OF ABSENCE

A Participant who commences a paid leave of absence during the Plan Year will continue to have contributions made and will be entitled to submit claims for eligible expenses incurred during the leave of absence.

ARTICLE IV

BENEFITS

4.1 BENEFIT OPTIONS

A Medical Flexible Spending Account will be established for each eligible Participant in the Plan in accordance with Article VI hereof.

4.2 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide Qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are included in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable

Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Medical Flexible Spending Account Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited to the Employer.

ARTICLE V PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.3.

5.2 SUBSEQUENT ANNUAL ELECTIONS

In order to participate in the Plan during the upcoming Plan Year, each Participant must complete an Enrollment/Change Form during the Election Period. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may enroll in the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by failing to enroll for the next Plan Year during the Election Period;

(c) A Participant who failed to enroll for the upcoming Plan Year but has carryover funds in his or her Medical Flexible Spending Account attributable to the prior Plan Year will remain eligible to participate and to submit claims for reimbursement for eligible expenses incurred during the upcoming Plan Year.

(d) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an Enrollment/Change Form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to authorize any Salary Redirections to the Plan for the upcoming Plan Year. To the extent such Participant has carryover funds in his or her Medical Flexible Spending Account, as permitted by Section 6.8, he or she will remain eligible to submit claims for reimbursement of eligible expenses incurred in the succeeding Plan Year.

5.4 CHANGE IN STATUS

Any Participant may change an election after commencement of the Plan Year (to which such election relates) and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and consistent with a qualified change in status, as defined in IRS regulations, the provisions of which are incorporated by reference herein. Qualified changes in status may include:

(a) **Legal Marital Status:** events that change a Participant's legal marital status (such as marriage, divorce, death of a spouse, legal separation or annulment);

(b) **Change in Number of Qualified Beneficiaries:** Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, death of a dependent or an event that causes a dependent or adult child to become eligible or ineligible for coverage under the employer's health plan.

(c) **Change in Employment Status:** Any of the following events that change the employment status of the Participant, Spouse or Dependent, such as a change from full-time to part-time employment, for you, your spouse or your dependent.

(d) **Change in Residency.** A change in the place of residence for you, your spouse or your dependent.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For purposes of this section, a change in status shall only include the above events or other events permitted by IRS regulations.

Note: A reduction of the annual election amount will not be considered to be necessitated by or consistent with a qualified change of status where a Participant's Medical Flexible Spending Account is Overspent at the time such change of status occurs.

Except as set forth in Section 3.4, the commencement or termination of an unpaid leave of absence does not constitute a qualifying status change that would permit a Participant to make a change of election amount.

**ARTICLE VI
MEDICAL FLEXIBLE SPENDING ACCOUNT**

6.1 ESTABLISHMENT OF ACCOUNT

This Medical Flexible Spending Account Plan is intended to qualify as a program under Code Section 125 and shall be interpreted in a manner consistent with such Code section. Participants who elect to participate in this program may submit claims for the reimbursement of eligible medical and dental care expenses not covered under the employer's health plan. All amounts reimbursed shall be paid from amounts allocated to the Participant's Medical Flexible Spending Account.

6.2 DEFINITIONS

For the purposes of this Article and the Plan the terms below shall have the following meaning:

(a) **"Earned Income"** means earned income as defined under Code Section 32(c)(2).

(b) **"Medical and Dental Care Expenses"** means qualified medical care expenses defined by IRS Publication 502 as amounts paid for: (1) the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body; (2) expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes; (3) medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins; (4) medical expenses include transportation amounts incurred primarily for and essential to medical care.

Out-of-pocket Medical and Dental Care expenses may be reimbursed for the employee, the spouse and IRS eligible dependents so long as: (1) expenses are qualified under IRS Code Section 105 and 213; (2) all other sources of reimbursement are exhausted (for example, health insurance plan); (3) reimbursement will not be sought from any additional source; and (4) documentation to substantiate expenses must be maintained and submitted for verification.

(c) **"Medical Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which his/her Cafeteria Plan Benefit Dollars may be allocated and from which Medical and Dental Care Expenses of the Participant, Spouse, or Dependent(s) may be reimbursed for eligible medical products and services.

(d) **"Qualifying Beneficiary"** means, for Medical Flexible Spending Account purposes,

(1) a Spouse is the legally married husband or wife of a Participant, but does not include an individual who is legally separated from a Participant under a court decree of legal separation;

- (2) an eligible child who:
 - a. Is a US citizen, or a resident of US, Mexico or Canada;
 - b. Is the biological or adopted son or daughter, stepson or stepdaughter of the Participant; and
 - c. Has not attained the age of 27 years as of the end for the taxable year;

There is no age requirement for a qualifying child if he/she is physically or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, either may establish a Medical Flexible Spending Account to be reimbursed for the child's qualified Medical and Dental Care Expenses;

- (3) a relative is deemed to be a Qualifying Beneficiary if he/she:
 - a. Is a US citizen, or a resident of US, Mexico or Canada
 - b. Has a specified family-type relationship to you
 - c. Is not someone else's qualifying child
 - d. Receives more than one-half of his/her support from you during the taxable year or;
 - a. If no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire taxable year and; and
 - b. Receives more than one-half of his or her support from you during the taxable year.

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Medical Flexible Spending Account.

6.3 MEDICAL FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Medical Flexible Spending Account for each Participant who elects to apply Benefit Dollars to Medical Flexible Spending Account benefits.

6.4 INCREASES IN MEDICAL FLEXIBLE SPENDING ACCOUNTS

A Participant's Medical Flexible Spending Account shall be credited each pay period by the amount that he has elected to apply toward his Medical Flexible Spending Account.

6.5 DECREASES IN MEDICAL FLEXIBLE SPENDING ACCOUNTS

A Participant's Medical Flexible Spending Account shall be reduced by the amount of any eligible Medical and Dental Care Expense reimbursements paid or incurred on behalf of a Participant, Spouse or Dependent pursuant to Sections 6.11 or 6.12 hereof.

6.6 ALLOWABLE MEDICAL FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT

Subject to limitations contained in Section 6.10 of this Program, and to the extent of the amount contained in the Participant's Medical Flexible Spending Account, a Participant who incurs eligible Medical and Dental Care Expenses shall be entitled to receive full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

6.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Plan Administrator shall furnish to each Employee who was a Participant and received benefits under Section 6.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year.

6.8 PLAN YEAR CARRYOVER PROVISION

Up to Five Hundred Dollars (\$500) of the amount remaining unused in a Participant's Medical Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Sections 6.12 or 6.13) may be carried over to the Participant's Medical Flexible Spending Account for the immediately following plan year. The carryover of up to \$500 may be used to pay or reimburse medical expenses under the Participant's Medical Flexible Spending Account incurred during the entire Plan Year to which it is carried over. For this purpose, the amount remaining unused as of the end of the Plan Year is that remaining after medical expenses have been reimbursed at the end of the run-out period for the Plan Year. In addition to the unused amounts of up to \$500 that a Participant carries over to the next year, the Participant may also elect up to the maximum salary reduction amount allowed under the Plan, which is Twenty-five Hundred Dollars (\$2500). The carryover of up to \$500 does not count against or otherwise affect the maximum salary reduction limit applicable to each Plan Year.

If a Participant is an Eligible Employee under Section 2.3 but has not elected to make salary redirections to the Plan for the upcoming Plan Year and has Twenty-five Dollars (\$25) or more in unused funds in his or her Medical Flexible Spending Account as of the end of the Plan Year (and after the processing of all claims for such Plan Year pursuant to Sections 6.11 or 6.12 hereof) such amount of Twenty-five Dollars or more and up to a maximum of Five Hundred Dollars (\$500) may be carried over to the Participant's Medical Flexible Spending Account for the immediately following Plan Year and used for reimbursement of medical expenses incurred during that Plan Year, even if the Participant's resulting account balance would be less than the annual minimum election amount of \$520. Any unused account balance in excess of Five Hundred Dollars (\$500) or less than Twenty-Five Dollars (\$25.00) will be forfeited pursuant to Section 6.9. All carryover funds must be used in the next Plan Year or they will be forfeited.

6.9 FORFEITURES—USE IT OR LOSE IT RULE

Any unused amount over Five Hundred Dollars (\$500.00) in a Participant's Medical Flexible Spending Account as of the end of any Plan Year (after the processing of all claims for

such Plan Year pursuant to Sections 6.11 or 6.12 hereof) shall be forfeited to the Employer. Any unused funds carried over pursuant to Section 6.8 will be forfeited if not used in the succeeding Plan Year.

If a Participant has not elected to participate in the Plan for the upcoming calendar year and has an unused amount of less than Twenty-five Dollars (\$25) in his or her Medical Flexible Spending Account at the end of any Plan Year (after the processing of all claims for such Plan Year pursuant to Sections 6.11 or 6.12) such amount will be forfeited to the Employer.

As set forth in Section 2.6, all unused amounts remaining in a Participant's account 90 days after either Termination of Employment or change in employment status will be forfeited to the Employer, unless COBRA continuation was elected, in which case unused funds remaining at the end of the Plan Year (and after the processing of all claims for such Plan Year pursuant to Sections 6.11 or 6.12 hereof) will be forfeited.

The Participant shall have no further claim to amounts forfeited to the Employer for any reason.

6.10 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Medical Flexible Spending Account shall be the lesser of \$2500 or the annualized amount elected by the Participant in the Salary Redirection Agreement (together with any carryover amounts from the preceding Plan Year), but in no event less than \$520 or, where applicable, the carryover balance remaining in a Participant's account from the immediately preceding Plan Year.

6.11 MEDICAL FLEXIBLE SPENDING ACCOUNT MANUAL CLAIMS

The Administrator shall direct the payment of all such MEDFLEX claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. In its discretion, the Administrator may utilize forms and require documentation of costs as necessary to verify the claims submitted. Acceptable forms of documentation include:

(a) An Explanation of Benefits (EOB) from the insurance carrier indicating the patient's name, date of service and out-of-pocket expenses associated with claim;

(b) An itemized statement for expenses not covered by insurance. The statement must include: (1) the patient's name; (2) date of service; (3) description of procedure; (4) physician name; and (5) the service charge;

(c) Prescription Drugs – A statement from the pharmacy indicating: (1) pharmacy name; (2) patient name; (3) date of prescription fill; (4) patient cost or co-pay; (5) Rx number; and (5) name of drug; or

(d) Eligible Over-the-Counter (OTC) Medications – A completed Letter of Medical Necessity Form including an itemized cash register receipt indicating: (1) medication name; and (2) OTC purchase date.

Pursuant to Code Section 105 cancelled checks, balance forward statements, and credit card and/or cash receipts cannot be used to substantiate expenses.

All incurred expenses must be substantiated by itemized receipts in order to be paid from a Participant's account. Failure of a Participant to produce missing or lost receipts will result in claim denial. If a Participant is unable to secure a replacement receipt or uses the Pre-Paid Benefits Card for expenses that are deemed ineligible, the claim will be denied and the Participant will be required to reimburse the plan with post-tax dollars. Failure to do so will result in de-activation of the Pre-Paid Benefits Card or the Administrator will offset the amount of the ineligible expense from the Participant's later substantiated claims until the full amount is repaid.

Claims for reimbursement. If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

6.12 MEDICAL FLEXIBLE SPENDING ACCOUNT PRE-PAID BENEFIT CARD CLAIMS

The Administrator shall permit payment of a Participant's MEDFLEX claims upon presentation of the Pre-Paid Benefits Card. The Pre-Paid Benefits Card may be used at qualifying medical merchant locations where a MASTERCARD™ credit card is accepted. The Card may only be used at those locations that use an Inventory Information Approval System (IIAS) and have a health-care related merchant category code. These include: physician offices, pharmacies, dental offices, grocery and discount stores, hospitals and vision centers. Qualified locations that use an IIAS will restrict use of the Pre-Paid Benefits Card to the purchase of items identified as eligible expenses. If a purchase has both eligible and ineligible expenses, the location will only accept the Pre-Paid Benefits Card for the eligible expenses. A Participant cannot use the Pre-Paid Benefits Card at locations that do not use an IIAS. Many transactions can be automatically substantiated by the card system using one of the following substantiation methods:

(a) Recurring Expense—Recurring transactions will be processed and approved without recurring documentation after the initial transaction's substantiating receipts or other documentation have been reviewed and approved. Documentation requests will not be required so long as the subsequent recurring expense equals the same amount, duration and provider as the initial transaction.

(b) Co-pay Matching – The expense specifically matches a health plan's co-pay. For example, if the healthcare provider office visit co-pay is \$15 and the payment for the office visit was \$15, a substantiating receipt may not be required.

(c) IIAS Approved—Your FSA-eligible products are purchased at a location that uses the IIAS. In the event that a Pre-Paid Benefits Card payment is denied at a location that uses the IIAS, a Participant will be required to submit substantiating documentation in order to receive reimbursement.

In its discretion, the Administrator may require documentation of costs as needed to verify claims paid by the Pre-Paid Benefits Card.

**ARTICLE VII
BENEFITS AND RIGHTS**

7.1 CLAIM FOR BENEFITS

(a) **Medical Flexible Spending Account claims.** Any claim for Medical Flexible Spending Account Benefits shall be made to the Administrator. If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered eligible for reimbursement from the Flexible Spending Account by the Administrator. If the Administrator denies a claim, the Administrator shall provide notice to the Participant, in writing, within 90 days after the claim is submitted unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (1) specific references to the pertinent Plan provisions on which the denial is based;
- (2) a description of any additional material or information needed to perfect the claim and an explanation as to why such information is necessary; and
- (3) an explanation of the Plan's claim procedure.

(b) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

- (1) request a review upon written notice to the Administrator;
- (2) review pertinent documents; and
- (3) submit issues and comments in writing.

(c) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(d) **Forfeitures.** Any balance remaining in the Participant's Medical Flexible Spending Account at the expiration of the time for claims reimbursement for each Plan Year shall be forfeited pursuant to Section 6.9, unless (1) such balance is eligible for carryover pursuant to Section 6.8; or (2) the Participant made a timely written claim for such Plan Year, which has been denied or is pending; in which event the amount of the

claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited unless it is otherwise eligible for carryover under Section 6.8.

7.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any amounts forfeited pursuant to Section 6.9 by virtue of a Participant's failure to incur qualified expenses or seek reimbursements in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by IRS regulations.

ARTICLE VIII ADMINISTRATION

8.1 PLAN ADMINISTRATION

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- (e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;
- (f) To approve reimbursement requests and to authorize the payment of benefits; and
- (g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the IRS regulations thereunder.

8.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

8.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder.

ARTICLE IX AMENDMENT OR TERMINATION OF PLAN

9.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

9.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time.

In the event the Plan is terminated, no further contributions shall be made and no further additions shall be made to the Medical Flexible Spending Account. All payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited to the Employer.

ARTICLE X MISCELLANEOUS

10.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 10.11.

10.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or gender- neutral, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

10.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any IRS regulations thereunder relating to cafeteria plans.

10.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

10.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant 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 which such discharge shall have upon him as a Participant of this Plan.

10.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

10.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of

each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

10.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

10.10 GOVERNING LAW

This Plan is governed by the Code and the IRS regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Connecticut.

10.11 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

10.12 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

10.13 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with IRS Regulation 1.125-3.

10.14 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment and Reemployment Rights Act (USERRA) and the regulations thereunder.

IN WITNESS WHEREOF, this Plan document is effective as of the first day of January 2013.

State of Connecticut
Office of the State Comptroller

By 
KEVIN LEMBO