THE SECTION 125

FLEXIBLE BENEFIT PLAN

FOR THE

EMPLOYEES OF

Tahlequah Hospital Authority DBA Northeastern Health System

PO Box 1008, Tahlequah, OK 74465
918-453-2170
Tax ID #73-6045246

INTRODUCTION

The purpose of this Summary Plan Description ("SPD") is to provide you with a brief description of the Section 125 Flexible Benefit Plan established by **Tahlequah Hospital Authority DBA Northeastern Health System** (the "125 Plan") to allow employees flexibility in paying for certain elected benefits with pre-tax compensation. Should you have further questions concerning the benefits described in this SPD, you should consult the plan documents, insurance certificates, policies, or other benefit brochures or material provided to you. Otherwise, questions concerning benefits or policy statements contained in this SPD should be referred to the person indicated below:

Name: Phyllis Smith

Title: Human Resources Director

Address: PO Box 1008, Tahlequah, OK 74465

Phone: 918-453-2170

The **Tahlequah Hospital Authority DBA Northeastern Health System** (the "Employer") currently intends to continue all of the benefits described in this SPD, however, the Employer reserves the right to amend, reduce, or terminate any of these benefits at any time.

Neither this SPD nor the official plan documents confer any contractual right to any person to either become or remain an employee of the Employer.

This SPD summarizes the principal features of the 125 Plan. The terms and conditions of the 125 Plan and the benefits provided through it are contained in the plan documents adopted by the Employer for the 125 Plan and the plans governing elected benefits, as applicable. If the provisions of this SPD conflict with those of an applicable plan document, the provisions of the applicable plan document will control.

TYPE OF PLAN AND CONTRIBUTIONS

What is the purpose of the Section 125 Plan?

It is a benefit plan, sometimes called a "cafeteria plan," that allows you, the employee, to pay for the benefits you choose with the benefit dollars available for your use from your Employer ("Flex Credits") or through a Salary Reduction Agreement with your Employer. Salary reduction means that you are able to use "pre-tax" dollars to pay for certain benefits. The 125 Flexible Benefit Plan for the Employees of **Tahlequah Hospital Authority DBA Northeastern Health System** will be referred to as the "125 Plan" throughout this SPD.

What benefits may be elected under the 125 Plan?

You may elect the following benefits for payment under the 125 Plan:

- Your share of costs under the following health plans or policies: Group Medical (including all supplemental and major medical plans), Cancer, Vision, Dental
- Dependent Day Care expenses allowable under the Dependent Day Care Plan.

Elected benefits under the aforesaid health plans or policies are paid through a health flexible spending account (Health FSA) and/or if applicable, health savings account (HSA). Elected benefits under the aforesaid Dependent Day Care Plan are paid through a dependent care flexible spending account (Dependent Day Care FSA).

What is the maximum dollar amount available for the purchase of benefits under the 125 Plan?

If you are eligible to participate in the 125 Plan, you may authorize your Employer to reduce your compensation by the amount needed to purchase the benefits you elected. You make your election for salary reduction on the benefit election form.

The maximum amount you may choose to pay for the purchase of benefits through salary reduction is **$30,000.00**. Throughout this SPD the term "Plan Year" means the **12** month period (or shorter under special circumstances) beginning **January 1, 2017.**

ELIBILITY AND PARTICIPATION

When do employees become eligible to participate in the 125 Plan?

All employees who are employed in a full-time or part-time status are eligible for 125 Plan participation on the **first day of the month following employment.**

Are employees automatically covered under the 125 Plan?

If you do not submit an enrollment form when you become eligible to participate or during Open Enrollment for each Plan Year, you will be automatically enrolled in the Employer's default benefits package, if applicable. You must submit an enrollment form to waive the default benefits, if applicable, or to be covered under any coverage different than the default benefits at the time you are eligible to participate and at each Open Enrollment. If you made an election of benefits for the prior Plan Year, your benefit elections will remain the same for all benefits other than the Health FSA and the Dependent Day Care FSA. You must submit an enrollment form to elect to participate in the Health FSA and the Dependent Day Care FSA at the time you become eligible to participate and during each Open Enrollment thereafter.

Throughout this SPD, the term "Open Enrollment" means a period of eight weeks immediately before the beginning of each Plan Year during which you will have the opportunity to make elections for benefits offered under the 125 Plan for the next Plan Year.

When may eligible employees enroll in the 125 Plan?

Generally, you must enroll during Open Enrollment for each Plan Year. You will receive specific information about Open Enrollment each year before Open Enrollment starts.

New employees or employees becoming eligible for plan participation in the Health FSA and the Dependent Day Care after the Plan Year's Open Enrollment, must enroll prior to the end of 180 continuous days' employment in a full-time or part-time status. If you do not enroll during this period you must wait until the next Open Enrollment prior to the next Plan Year to enroll in benefits offered through the 125 Plan.

If you are on FMLA leave during Open Enrollment, your Employer will provide you with Open Enrollment information and you may make changes to your coverage during Open Enrollment. The same rules regarding benefit elections that apply to other participants in the 125 plan will also apply to you during Open Enrollment.

PLAN ELECTIONS AND ELECTION CHANGES

How do eligible employees enroll in the 125 Plan?

You must complete an election form to participate. If your Employer offers a default benefits package you must complete an election form to waive coverage under the 125 Plan. This form must be completed before the beginning of the Plan Year, or by the date you become eligible to participate in the 125 Plan, if later.

May benefit elections be changed during the year?

With the exception of the HSA (for which you may make election changes once each month), you may not change your benefit elections during a Plan Year, unless that change is the result of one of the qualified events described below and the change is on account of and corresponds with the qualified event. All changes (except for changes made due to certain special enrollment rights) will be effective the first of the month following the completion of the forms required to make the election change and will remain in effect for the remainder of the Plan Year.

The following information <u>does not apply</u> to election changes for the Health FSA. See the Health FSA section for additional information.

If all requirements are met, the following are circumstances under which election changes may be made:

<u>Certain changes in status.</u>

You may change your election if one of the following events occurs:

- A change in your legal status, such as marriage, death of spouse, divorce, legal separation or annulment;
- A change in the number of your dependents, such as birth, death, adoption or placement for adoption;
- A change in employment, including any employment status change affecting benefit eligibility of you, your spouse or your dependent, such as termination or commencement of employment, a change in hours, a strike or lockout, a commencement or return from an unpaid leave of absence, switching from salaried to non-salaried, union to non-union, full-time to part-time (or vice versa) and a change in worksite;
- Dependent satisfies or ceases to satisfy dependent eligibility requirement, including attainment of age, student status, etc.; or
- Residence change of you, your spouse or your dependent affecting the employee's eligibility for coverage.

Change in Cost of Coverage (does not apply to Health FSA).
If the cost you must pay for health coverage or dependent care significantly increases during the Plan Year, you may choose to change your election to increase your contributions to pay for the increased cost; choose another benefit package that offers similar coverage; or drop coverage (but only if there is no other similar benefit package offered). If the cost for health coverage or dependent care significantly decreases during the Plan Year, you may choose to change your election to decrease your contributions to pay only for the decreased cost or choose the benefit package if you are not enrolled in that package that experienced the decreased cost (and drop alternate coverage if you are already enrolled in other coverage).

Change in Coverage (does not apply to Health FSA).
You may change your election if one of the following events occurs:

- There is a significant curtailment of coverage;
- There is an addition or significant improvement of benefit options offered under the 125 Plan;
- You, your spouse, or dependent loses coverage under another Employer plan;
- There is a change of election under another Employer plan; or
- Coverage with your dependent care provider changes.

Medicare or Medicaid (does not apply to Dependent Day Care FSA).
If you, your spouse, or your dependent becomes entitled to or loses entitlement to Medicare or Medicaid, you may change your election for that person accordingly.

Certain Judgment, Decrees, and Orders (does not apply to Dependent Day Care FSA).
A judgment, decree, or order relating to divorce, separation, annulment, or custody requires you to change coverage under your benefits, you may make a corresponding change in your election.

Once the election form is completed, are employees automatically covered under the insurance benefits elected?

Yes. You are not required to complete an application in order to participate, however, some benefits may require that you and/or your dependents meet underwriting requirements. Please refer to the documents and other material about a specific benefit to find out about any coverage requirements that may apply to you.

May I stay in the 125 Plan if I am absent on a Family and Medical Leave?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA) for periods totaling 12 weeks during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. Of course, you must pay the premiums for the coverage during your absence using one of the following methods:

Prepayment. Under the prepayment option, you may increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave.

Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid through salary reduction as if you had not taken the leave. If at any point your FMLA leave is unpaid and you choose this option, you will have to reimburse the Plan at regular intervals from your after-tax funds for the premiums that come due during the leave.

Catch up: The employee and Employer agree before the FMLA leave begins that the Employer will advance payment of the employee's share of the cost of coverage during the leave. The employee must agree to pay the Employer back for the amounts when he returns from leave. Upon return from leave, the employee makes catch-up salary reduction contributions to cover his share of the cost of coverage during the leave. In addition, the pre-leave salary reduction election resumes for the duration of the Plan Year unless the employee makes a change in election as allowed under the permitted election change regulations (i.e., for change in status) upon return from leave.

HEALTH FSA

Who can participate in the Health FSA?

Health FSA Eligibility is 180 continuous days of full-time or part-time status.

How do I become a Participant?

You become a Participant in the Health FSA by electing Health FSA benefits during your initial enrollment or during Open Enrollment. At Open Enrollment each year, you must make an election, even if you do not change your current election. You may also become a Participant if you experience a change in status event that permits you to enroll mid-year.

When you complete the Salary Reduction Agreement, you specify the amount you wish to contribute with pre-tax contributions and/or Flex Credits, to the extent available. Your enrollment material will indicate if Flex Credits are available for Health FSA coverage. Thereafter, each paycheck will be reduced by an amount equal to a prorated share of the annual contribution, reduced by any Flex Credits allocated to your Health FSA.

Once you become a Participant, your eligible dependents also become covered. For purposes of the Health FSA, eligible dependents are the following:

- Your legal spouse (as determined by state and federal law) and
- Any other individuals who would qualify as a tax dependent under Code Section 105(b).

May anyone other than my spouse and tax dependents receive benefits under my Health FSA?

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health FSA, the Health FSA will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health FSA does not otherwise provide. "Alternate recipients" include any child of the Participant who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree, or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health FSA, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing QMCSOs. A QMSCO may permit reimbursement of eligible expenses for the alternate recipients named in the order from your Health FSA, but this does not necessarily mean you will be entitled to a mid-year change in election to increase your Health FSA election.

What is the maximum annual amount that I may elect under the Health FSA?

You may elect any annual reimbursement amount subject to a maximum of **$2,600.00**. You will be required to pay the annual contribution equal to the annual reimbursement amount you have elected reduced by any Flex Credits allocated to your Health FSA. Any change in your Health FSA election also will change the maximum available reimbursement for the period of coverage after the election.

How do I get reimbursed from the Health FSA?

If your claim for reimbursement is approved in accordance with the terms of this Plan, you may receive the reimbursement in one of several ways:

- A check made payable to you;
- Electronic transfer to your personal checking or savings account (if offered and if specifically authorized by the Participant);
- If an electronic payment card is used, payment may be made directly to the health care provider at the point of purchase (subject to the Plan's debit card rules).

What amounts will be available for reimbursement at any particular time during the Plan Year?

So long as coverage is effective, the full annual amount of Health FSA reimbursement you have elected, reduced by the amount of previous reimbursements received during the Plan Year, will be available at any time during the Plan Year, without regard to how much you have contributed.

How do I receive reimbursement under the Health FSA?

Under the Health FSA, you have two reimbursement options. You may complete and submit a claim form for reimbursement either by mail, through online submission, or by using the American Fidelity mobile app. Alternatively, if applicable you can use your Health FSA debit card to pay the expense. The following is a summary of how both options work.

Traditional Claims: When you incur an Eligible Medical Expense (described below), you file a claim with American Fidelity by completing and submitting an Expense Reimbursement Voucher or completing the required information online at www.americanfidelity.com or through the mobile app. You may obtain an Expense Reimbursement Voucher from your Employer or American Fidelity. You must include with a reimbursement submission, a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following:

- Name of person receiving service;
- Name and address of service provider;
- Nature of service or supplies (drug name if a prescription or over-the-counter medication);

- Amount of reimbursable expense under the Plan; and
- Date(s) of service.

American Fidelity Assurance will process the claim once it receives the Expense Reimbursement Voucher or online or mobile app submission from you. Reimbursement for expenses that are determined to be eligible will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Expense you will receive notification of this determination. You must submit all claims for reimbursement during the Plan Year in which they were incurred or before the end of the **90** day period following the end of the Plan Year.

Debit Card. Alternatively, you may be able to use, if enabled as a 125 Plan option, a debit card to pay the expense. In order to be eligible for the debit card you must agree to abide by the terms and conditions of the debit card program including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. Even if you use the debit card to pay an expense, you may still need to submit a written statement from an independent third party as described under Traditional Claims above.

What expenses are eligible for reimbursement from my Health FSA?

Only "Eligible Medical Expenses" are eligible for reimbursement (for rules applicable to the Limited Purpose Health FSA, see below). An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Internal Revenue Code ("Code") Section 213(d); and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

"Stockpiling" of over-the-counter items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such items could be used during the Plan Year (as determined by the Employer or its delegate).

In addition, in accordance with IRS regulations, certain expenses are not reimbursable under any Health FSA:

- Health insurance premiums;
- Expenses incurred for qualified long-term care services;
- Over-the counter medications unless prescribed by a physician; and
- Any other expenses that are specifically excluded by the Employer.

When must the expenses be incurred in order to receive reimbursement?

Expenses must be incurred ***during*** the Plan Year and while you are a Participant in the 125 Plan. "Incurred" means that the service or treatment giving rise to the expense has been provided. If you pay for an expense before you are provided the service or treatment, the expense may not be reimbursed until you have been provided the service or treatment. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Salary Reduction Agreement or election form becomes effective, or for any expenses incurred after the close of the Plan Year or after a separation from service or loss of eligibility (except for expenses incurred during an applicable COBRA continuation period).

If your Employer has adopted a grace period, you may also be able to use amounts allocated to the Health FSA that are unused at the end of the Plan Year for expenses incurred during the grace period following the end of the Plan Year. The grace period ends the 15th day of the third month following the last day of your Plan Year. For a Plan Year ending December 31, 2017, the grace period would end March 15, 2018.

What if the Eligible Expenses I incur during the Plan Year are less than the annual amount I have elected for my Health FSA?

You will forfeit any amount you elected to have contributed to your Health FSA if it has not been applied to provide reimbursement for Eligible Expenses incurred during the Plan Year that are submitted for reimbursement within the **90** day runoff period after the end of the Plan Year, or grace period if applicable. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

If your Employer has adopted the Carryover Provision, you will not also have the grace period. However, the Carryover allows unused amounts of $500.00 or less at the end of the plan year to be carried over into the immediately following plan year to be used in that plan year. Claims submitted during the run-off may be reimbursed from the carried over amounts.

What happens if a claim for benefits under the Health FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims Review Procedure in this SPD for a detailed summary of the claims procedures that applies to this Plan.

What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Health FSA that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year as set forth in this SPD, or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), your Employer may recoup the excess reimbursements in one or more of the following ways:

- Your Employer (or its delegate) will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer immediately after receipt of such notification;
- Your Employer may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or
- Your Employer may withhold such amounts from your pay (to the extent permitted under applicable law).

If your Employer is unable to recoup the excess reimbursement by the means set forth above, the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

What happens to my Health FSA if I take an approved leave of absence?

If your Health FSA coverage ceases during an FMLA leave, you may, upon returning from FMLA leave, elect to be reinstated in the Health FSA at the same coverage level in effect before the FMLA leave. Expenses incurred during the period you did not participant in the Health FSA are not eligible for reimbursement under the Health FSA after your return and reinstatement.

If you are on FMLA leave at the end of a Plan Year, you will need to elect Health FSA coverage during Open Enrollment to have coverage in effect after the end of the 125 Plan Year.

How long will the Health FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time and for any reason.

How does my Limited Purpose Health FSA differ from a Health FSA?

If you participate in the Health FSA, you will be ineligible to participate in a Health Savings Account (HSA) unless you only participate in the Limited Purpose Health FSA. The Limited Purpose Health FSA only allows reimbursement for:

- Services or treatments for dental care (excluding premiums), and/or
- Services or treatments for vision care (excluding premiums).

Your participation in the Health FSA could also disqualify your spouse from establishing and making or receiving tax favored contributions to an HSA as defined in Code Section 223 unless you have elected the Limited Purpose Health FSA.

DEPENDENT DAY CARE FSA

Who can participate in the Dependent Day Care Flexible Spending Account (Dependent Day Care FSA)?

Dependent Day Care eligibility is 180 continuous days of full-time or part-time status.

How do I become a Participant?

You become a Participant in the Dependent Day Care FSA by electing day care benefits during your initial enrollment period or Open Enrollment period. At Open Enrollment each year, you must make an election to participate in the Dependent Day Care FSA, even if you do not change your current election amount.

You may also become a Participant if you experience a change in status event or cost or coverage change that permits you to enroll mid-year. See the section in this SPD about Change in Elections for more details regarding mid-year election changes and the effective date of those changes.

When you complete the Salary Reduction Agreement, you specify the amount you wish to contribute with pre-tax contributions and/or Flex Credits, to the extent available. Your enrollment material will indicate if Flex Credits are available for day care coverage. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution, reduced by any Flex Credits allocated to your Dependent Day Care FSA.

What is my "Dependent Day Care Account"?

If you elect to participate in the Dependent Day Care FSA, your Employer or its delegate will establish a "Dependent Day Care Account" to keep a record of the reimbursements to which you are entitled, as well as the contributions you elected to withhold for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

When does my coverage under the Dependent Day Care FSA end?

Your coverage under the Dependent Day Care FSA ends on the earlier of the following to occur:

- The date that you elect not to participate in accordance with the election rules of the 125 Plan;
- The last day of the Plan Year unless you make an election during Open Enrollment for the following year;
- The date that you no longer satisfy the Dependent Day Care FSA eligibility requirements;
- The date that you terminate employment; or
- The date that the Plan is terminated or you, or the class of eligible employees of which you are a member, are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the Plan Year, you may submit for reimbursement Eligible Day Care Expenses (described below) incurred for services provided prior to the date of separation, but during the Plan Year, up to the amount of your Dependent Day Care Account.

What is the maximum annual amount I may elect under the Dependent Day Care FSA?

The maximum annual amount is currently $5,000 per Plan Year if you:

- Are married and file a joint return;
- Are married but your spouse maintained a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Day Care FSA; or
- Are single.

If you are married and reside together, but file a separate federal income tax return, the maximum that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the Plan Year cannot exceed the lesser of your earned income (as defined in Code Section 32) or your spouse's earned income. Special rules apply if your spouse is:

- Physically or mentally incapable of caring for himself or herself, or
- A full-time student (as defined by Code Section 21).

Ask your American Fidelity representative for more information if you think these rules may apply to you.

What is an "Eligible Day Care Expense" for which I can claim a reimbursement?

Generally, an expense must meet all of the following conditions for it to be an "Eligible Day Care Expense":

- The expense is incurred (expenses are considered incurred only if the service has already occurred) for services rendered after the effective date of your election to participate in the Dependent Day Care FSA and during the Plan year to which it applies;
- Each individual for whom you incur the expense is a "Qualifying Individual". A "Qualifying Individual" is:
    - An individual under age 13 who is your "qualifying child" as defined in Code Section 152(a)(1). Generally, a "qualifying child" is your child (including a brother, sister, step sibling) or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with you for more than half the year and does not provide over half of his/her support. There is a special rule for children of divorced parents. The child is a Qualifying Individual of the "custodial parent", as defined in Code Section 152(e).; or

    - A spouse or other tax dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.
- The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp and for kindergarten (or above) do not qualify;
- If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, and such dependent regularly spends at least 8 hours per day in your home;
- If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), and the center complies with all applicable state and local laws and regulations;
- The expense is not paid or payable to a child of yours who is under age 19 by the end of the calendar year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent; and
- You supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an reimbursable expense if you have any doubts.

When must the expenses be incurred in order to receive reimbursement?

Eligible day care expenses must be incurred ***during*** the Plan Year. You may not be reimbursed for any expenses arising before the Dependent Day Care FSA becomes effective, before your Salary Reduction Agreement or election form becomes effective, or for any expenses incurred after the close of the Plan Year and after your participation in the Dependent Day Care FSA ends.

How do I receive reimbursement under the Dependent Day Care FSA?

When you incur eligible day care expenses, you submit a written or electronic claim for reimbursement to American Fidelity You may obtain an Expense Reimbursement Voucher from American Fidelity. You must include this form or provide all information requested for online submission or through the mobile app with your request for reimbursement. If there are enough funds in your Dependent Day Care FSA, you will be reimbursed for your Eligible Expenses as soon as possible after receiving the claim and processing it. If your claim was for an amount that was more than your current Dependent Day Care FSA balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, you may not be reimbursed for any total expenses above your annual election amount. You may not be reimbursed for any

expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for DCAP benefits?

You will forfeit any amount you elected to have contributed to your Dependent Day Care FSA if it has not been applied to provide reimbursement for Eligible Expenses incurred during the Plan Year that are submitted for reimbursement within the **90** day run-out period after the end of the Plan Year. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations (per the Plan Administrator's sole discretion).

Will I be taxed on the reimbursements I receive from my Dependent Day Care FSA?

You will not normally be taxed on your dependent care expense reimbursements so long as your family's aggregate dependent care reimbursements (under this Dependent Day Care FSA and/or another employer's Dependent Day Care FSA) do not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

If I participate in the Dependent Day Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under the Dependent Day Care FSA, although the amount of dependent care expenses you incur in excess of the amounts reimbursed from your Dependent Day Care FSA may be eligible for the dependent care credit. You should check with your tax advisor for advice about your situation.

What happens if my claim for reimbursement under the Dependent Day Care FSA is denied?

You will have the right to a full and fair review process. You should refer to the Claims For Benefits section in this SPD for additional information.

What happens if I receive erroneous or excess reimbursements?

If, as of the end of any Plan Year, it is determined that you have received payments under this Dependent Day Care FSA that exceed the amount of Eligible Expenses that have been properly substantiated during the Plan Year as set forth in this SPD or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), the Employer or its delegate may recoup the excess reimbursements in one or more of the following ways:

- The Employer will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty (60) days of receipt of such notification;
- The Employer may offset the excess reimbursement against any other Eligible Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or
- The Employer may withhold such amounts from your pay (to the extent permitted under applicable law).

If the Employer is unable to recoup the excess reimbursements by the means set forth above, the Employer will treat the excess reimbursement as it would any other bad business debt. This could result in adverse tax consequences to you.

How long will the Dependent Day Care FSA remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

CLAIMS FOR BENEFITS

How does an employee file for benefits under the coverage elected?

To obtain benefit payments under the Plan you must comply with the rules and procedures of the particular benefit you elected. For claims procedures for the Health FSA and Dependent Day Care FSA, see the applicable question in this SPD for those benefits. If you have questions concerning insured benefit payments, you should contact the insurance carrier or the party listed at the beginning of this handbook.

What is the procedure to follow if benefits are denied?

Should you disagree with the benefit amount or if your claim is denied, you may request review by filing a written request in care of the Employer. You must file this written request within 60 days after receiving payment or denial.

You will be notified in writing of the final decision within 60 days of receipt of your request for review. A thorough explanation as to the reason for denial will be furnished.

Some special rules apply to claims appeals under the Health FSA benefits, if offered under the Plan. The Employer is responsible for evaluating all claims for reimbursement under the Health FSA. The Employer will decide your claim within a reasonable time not longer than 30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Employer, including in cases where a claim is incomplete. You will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision by the Employer is expected to be made. You will be given 45 days in which to complete an incomplete claim. The Employer may require such other evidence as it deems necessary to decide your claim.

If the Employer denies your initial appeal, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

- The specific reason or reasons for the denial,
- Reference to the specific plan provision on which the denial is based,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Employer's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

If your initial appeal is denied in whole or in part, you may appeal to Employer for a review of the denied appeal. Your appeal must be made in writing within 180 days of the Employer's initial notice of adverse benefit determination, or else you will lose the right to appeal your denial.

Your written appeal should state the reasons that you feel your claim appeal should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal. The Employer will review all written comments you submit with your appeal.

The Employer will review and decide your appeal within a reasonable time not longer than 60 days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial appeal denial and will not be that individual's subordinate. The Employer may require such other evidence as it deems necessary to decide your appeal. If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the denial,
- The specific Plan provision(s) on which the decision is based,
- A statement of your right to review (on request and at no charge) relevant documents and other information,
- If the Employer relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request," and
- A statement of your right to bring suit under ERISA § 502(a) if applicable.

You may only bring suit whether under ERISA or otherwise within 1 year of the date on the final determination of your appeal.

TERMINATION OF BENEFITS

When will my benefits under the 125 Plan terminate?

Benefits under the 125 Plan that are described in this handbook can terminate (unless the Plan provides otherwise) if:

- Your employment terminates;
- The policy terminates;
- The provider goes out of business;
- You discontinue any required contributions; or
- The Employer amends or terminates the Plan.

In any case of reduction of benefits by Plan amendment or termination, you must understand that although the Employer intends to continue these Plans indefinitely, for business reasons it must reserve the right to change or discontinue the Plan at any time. If the Employer terminates any benefit or the 125 Plan for any reason and does not replace the coverage with comparable benefits, you will receive ample notice.

What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your spouse's and dependent's right, to continue the same coverage under a component medical benefit plan that was in place the day before a Qualifying Event if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation Coverage under federal law is provided under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).

A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- Your death;

Certain Participants with the Health FSA benefits will be eligible for COBRA Continuation Coverage if they have positive Health FSA balances at the time of a Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the Health FSA will cease at the end of the Plan Year and may not be continued for the next Plan Year. You may pay premiums for such coverage on an after-tax basis, but not beyond the current Plan Year.

Your ERISA Rights

The 125 Plan, HSA and Dependent Day Care FSA components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and other benefit plans you pay for through the 125 Plan are governed by ERISA. This SPD does not describe the other benefit plans you pay for through the 125 Plan. Consult the benefit plan specific document and the separate SPDs for those benefits.

If you participate in the Health FSA you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Receive Information About Your Plan and Benefits;
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Tahlequah Hospital Authority DBA Northeastern Health System, as Plan Administrator, is required by law to furnish each Participant with a copy of this summary annual report.

COBRA and HIPAA Rights

You may continue any medical and dental coverage (and, in some cases, your Health FSA coverage) for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Note: This does not apply to the Dental Insurance Plan or Health FSA, which are “excepted benefits” under HIPAA.)

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Tahlequah Hospital Authority DBA Northeastern Health System, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL INFORMATION

A. PLAN NAME AND NUMBER

Plan Name – **Tahlequah Hospital Authority DBA Northeastern Health System Flexible Benefit Plan** (the "Plan")

Plan Number - **501**

B. NAME, ADDRESS, TELEPHONE NUMBER AND TAX IDENTIFICATION NUMBER OF PLAN SPONSOR AND PLAN ADMINISTRATOR

Tahlequah Hospital Authority DBA Northeastern Health System
PO Box 1008, Tahlequah, OK 74465
918-453-2170
Tax ID #73-6045246

C. PARTICIPATING EMPLOYERS

The Employer whose employees are covered by the Plan is the **Tahlequah Hospital Authority DBA Northeastern Health System.**

A complete updated list of the Employers participating in the Plan may be obtained upon written request to the Plan Administrator and is also available at the office of the Plan Administrator for examination by Participants and beneficiaries.

D. NAME AND ADDRESS OF THE AGENT FOR SERVICE OF LEGAL PROCESS

Tahlequah Hospital Authority DBA Northeastern Health System
Attn: Jim Berry, Hospital Administrator
PO Box 1008
Tahlequah, OK 74465
918-453-2373

E. PLAN YEAR

The Plan Year for purposes of maintaining the Plan's records, is the annual period **January 1 through December 31.**

F. TYPE OF ADMINISTRATION

The Plan is self-administered by the Employer. However, the Employer has by contract obtained the performance of certain administrative functions such as the review,

processing, and payment of claims from a Claims Recordkeeper ("Recordkeeper"). The name, address, and telephone number of the Recordkeeper is:

American Fidelity Assurance Company
2000 N Classen Blvd
Oklahoma City, OK 73106
(800) 654-8489

G. FUNDING MEDIUM

The Health FSA Component is a group health plan. The Health FSA is self-funded by the Employer. It is a contract administration plan. A third-party Recordkeeper processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

H. QUALIFIED MEDICAL SUPPORT ORDERS

The Medical and Dental Insurance Plans and the Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employer.

G. INSURERS

Insurance contracts have been purchased from insurers to fund certain benefits available under the 125 Plan. The insurers are as follows:

Type of Benefits	Insurer
Cancer	**Aflac**
Dental	**Principal**
Disability	**Aflac**
Disability	**American Fidelity**
Medical	**Web TPA**
Medical	**Aflac**
Vision	**VSP**
Health FSA	**American Fidelity**
Dependent Care FSA	**American Fidelity**
Health Savings Account	**First Fidelity Bank NA**