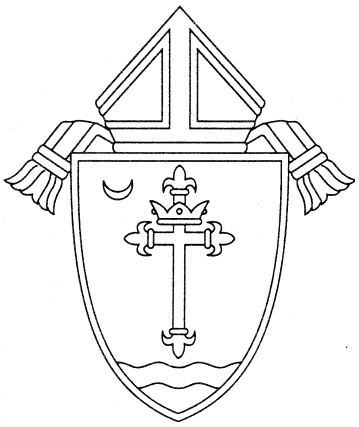
ARCHDIOCESE OF ST. LOUIS



FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Group Numbers: A03100-A03999

Premium Payment Plan

Medical Reimbursement Plan

Dependent Care Assistance Program Reimbursement Plan

JULY 1, 2003
REVISED: JULY 1, 2023

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INTRODUCTION

Archdiocese of St. Louis has chosen TRISTAR Benefit Administrators as the Administrative Services firm for the Archdiocese of St. Louis Flexible Benefits Plan (the Plan).

If the employee and/or covered dependents have any questions about this Archdiocese of St. Louis Flexible Benefits Plan, they should contact TRISTAR Benefit Administrators. The staff of TRISTAR Benefit Administrators is there to serve.

The TRISTAR Benefit Administrators telephone number is:

800-456-4584

All claims and correspondence should be submitted to the following:

TRISTAR Benefit Administrators
5820 S. Eastern Avenue, Suite 250
Las Vegas, NV 89119

flex@tristargroup.net

tristar.summitfor.me

This plan will comply with any current and/or future emergency legislation enacted, including, but not limited to, claim processing procedures, enrollment and/or eligibility guidelines, and COBRA and/or continuation of coverage guidelines. Such legislation may include, but is not limited to, responses to a pandemic, such as the FFCRA or the CARES Act.

FLEXIBLE BENEFITS PLAN QUESTIONS AND ANSWERS

Q-1. What is the purpose of the Plan?

This Plan is designed to permit an Eligible Employee to pay on a pre-tax basis for his share of premiums under the Insurance Plan, and to contribute to an account for pre-tax reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

Q-2. What benefits are provided by the Plan?

The plan includes the following three component benefit plans:

a. **Premium Payment Component** - Under the Premium Payment Component of the Plan an Eligible Employee's share of the premiums under the Insurance Plan(s) will be paid for with pre-tax Salary Reduction dollars.

b. **Medical Care Reimbursement Component** - Permits an Employee to pay for the Employee's and any eligible dependent's qualifying Medical Care Expenses (defined in Q-21) that are not otherwise reimbursed by insurance with pre-tax dollars, subject to the current IRS Allowable Maximum, which is $3,050 for 2023; and

c. **Dependent Care Assistance Program (DCAP)** - Under the DCAP Component of this Plan, Participant may elect to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses and to pay the premium for such benefits via Salary Reductions.

Q-3. Who can participate in the Plan?

An Eligible Employee will first become eligible to make an election to receive benefits on the later of his Employment Commencement Date or the date he becomes an Eligible Employee. An Eligible Employee who does not elect to receive benefits when first eligible may not enroll until the next Open Enrollment Period.

An "Eligible Employee" means:

1. Employees working at least 1,000 hours annually;

2. Teachers with one-half-time or more contracts;

3. Religious Employees on assignment with the Archdiocese;

4. Kenrick-Glennon Seminarians who are eligible for coverage under the Archdiocese of St. Louis Health Care Plan; and

5. Permanent Deacons who are eligible to participate in the Archdiocese of St. Louis Health Care Plan.

"Eligible Employee" does not include any individuals classified by the Employer as contract workers, independent contractors, casual employees, any leased employees as defined in Code Section 414(n), or any individuals who perform services for an Employer but who are paid by a temporary or other employment or staffing agency.

Those employees who actually participate in the Plan are called "Participants." A Participant will cease to be a Participant in this Plan upon the earliest of:

1. The expiration of the Plan Year for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);

2. The termination of this Plan;

3. The date on which the Participant ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee; or

4. The date the Participant revokes his election to receive benefits under a circumstance when such change is permitted under the terms of this Plan.

If no beneficiary is named or if no beneficiary survives the employee, the Plan, at their option, may pay eligible medical or dependent care account balances to 1) the executors or administrators of the employee's estate; or 2) all to the surviving Spouse; or 3) if the Spouse does not survive the employee, in equal share to the surviving children; or 4) if no child survives the employee, in equal share to the surviving parents.

Q-4. How do I become a participant?

1. *Election When First Eligible.* The election will be made by submitting an Enrollment Form (paper or online) to the Administrator.

2. *Elections During Open Enrollment Period.* During each Open Enrollment Period with respect to a Plan Year, the Administrator will provide an Enrollment Form to each Employee who is eligible to receive benefits in this Plan. The Enrollment Form will enable the Employee to elect to receive benefits in the various components of this Plan for the next Plan Year, and to authorize the necessary Salary Reduction to pay for the benefits elected. The Enrollment Form must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to receive benefits during an Open Enrollment Period, he will become eligible to receive benefits on the first day of the next Plan Year. The Enrollment Form can be completed on paper, or via an online document.

3. *Eligible Employee Who Fails to File an Enrollment Form.* If an Eligible Employee fails to file (or fails to timely file) an Enrollment Form within the time frames described above, then the Employee may not elect to receive benefits in the Plan until the next Open Enrollment Period or until a change in status event would justify an earlier mid-year election change. If an Eligible Employee who fails to file an election is eligible for

Insurance Plan benefits, his share of the premiums for such benefits may be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period, a timely Enrollment Form to participate in the Premium Payment Component of this Plan.

Q-5. What tax advantages would I experience as a result of participating in the Plan?

You may save both federal income tax and FICA (Social Security) taxes by participating in the Flexible Benefits Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Premium Payment Component under the Flexible Benefits Plan. Suppose that you are married and have one child and that your share of the required contributions for Premium Payment Component for family coverage is an annual total of $6,400. Suppose also that your gross pay is $75,000 and your spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce $6,400 to pay for the Medical Insurance contributions, then your annual take-home pay would be $56,627. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only $55,177. This is because by participating in the Flexible Benefits Plan for Medical Insurance contributions, you will be considered for tax purposes to have received $68,600 in gross pay, so you save $1,450 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

Caution: The amount of the contributions used in this example is not meant to reflect your actual Contributions - the actual contribution amounts will be described in a document provided separately to you by Archdiocese of St. Louis.

	With Cafeteria Plan *		**No Cafeteria Plan**
1. Adjusted Gross Income	$75,000		$75,000
2. Salary Reductions for Premiums	($6,400)		$0
3. W-2 Gross Wages	$68,600		$75,000
4. Standard Deduction	($9,700)		($9,700)
5. Exemptions	($9,300)		($9,300)
6. Taxable Income (line 3 minus lines 4 & 5)	$49,600		$56,000
7. W-2 Gross Wages	$68,600		$75,000
8. Federal Income Tax (line 6 @ tax schedule)	($6,725)		($7,685)
9. FICA Tax (7.65% of line 3)	($5,248)		($5,738)

10. After-Tax Premium Payments	$0		($6,400)
11. Pay after Taxes and Premium Payments (line 7 minus lines 8, 9, & 10)	$56,627		$55,177

Q-6. Can I change my election during the Plan Year?

Except as described below in this section a Participant's election under the Plan is irrevocable for the duration of the Plan Year to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Plan Year regarding:

1. Participation in this Plan;

2. Salary Reduction amounts; or

3. Election of particular component plan benefits.

The exceptions to the irrevocability requirement which would permit the Participant to make a mid-year election change in benefits and/or Salary Reduction amounts for the Premium Payment Component, the DCAP, and the Medical Reimbursement Component are as set forth below.

1. **Leaves of Absence.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits, and DCAP Benefits). You may change an election under the Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. **Change in Status.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits as limited below, and DCAP Benefits as limited below). If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which Archdiocese of St. Louis determines are permitted under subsequent IRS regulations:

    a. a change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse);

        "Spouse" means the person to whom the Participant is married, as recognized by the laws of the Catholic Church or the laws of the State of Missouri. It is always understood for this purpose that the Spouse is of the opposite sex. Notwithstanding the above, for purposes of the Dependent Care Assistance Program Component, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish

more than half of the cost of maintaining the principal place of abode of the Participant.

b. a change in the number of your tax Dependents (such as the birth of a child, adoption, or placement for adoption of a Dependent, or death of a Dependent);

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 152; except that: (a), for purposes of accident or health coverage, any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the year) is treated as a dependent of both parents; or (b) for purposes of accident or health coverage, any child under the age of 27; and (c) for purposes of the Dependent Care Assistance Program Component, a dependent means a qualifying individual as defined in Code § 21(b)(1) with respect to the Participant and in the case of divorced parents, the child shall, as provided in Code § 21 (e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code § 152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health FSA Plan of this Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, as defined in ERISA § 609(a), even if the child does not meet the definition of Dependent.

c. any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status:

i. termination or commencement of employment;

ii. a strike or lockout;

iii. a commencement of or return from an unpaid leave of absence;

iv. a change in worksite;

v. switching from salaried to hourly - paid (or visa-versa);

vi. switching from union to non-union (or visa-versa);

vii. switching from part-time to full-time (or visa-versa);

viii. incurring a reduction or increase in hours of employment; or

ix. any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

d. an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age or similar circumstances); or

e. a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs, you must inform Archdiocese of St. Louis and complete a new election for Pre-Tax Premiums within 31 days of the occurrence.

3. **Change in Status - Other Requirements.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits as limited below, and DCAP Benefits as limited below). If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) will determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Expense reimbursement, the event may also affect eligibility for the dependent care exclusion). In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   a. Loss of Spouse or Dependent Eligibility; Special Continuation Rules. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage and Health Care Expense Reimbursement benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, you may only elect to cancel accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status;

      Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the Plan Year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the Plan Year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or a Dependent elect continuation coverage under Archdiocese of St. Louis's plan, you may be able to increase your contribution to pay for such coverage;

b. Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan;

c. Dependent Care Assistance Program (DCAP) Benefits. With respect to the DCAP Expense Reimbursement benefit, you may change or terminate your election only if:

i. such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the Plan; or

ii. your election change is on account of and conforms with a Change in Status that affects the eligibility of dependent care expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a Plan Year to fund dependent care coverage for his daughter. In the middle of the Plan Year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

4. **Special Enrollment Rights.** (Applies to Premium Payment Benefits that are Group Health Plans, but not to Medical Care Reimbursement Benefits or DCAP Benefits). If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e. due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of a continuation period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption, or

placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights;

5. **Certain Judgments, Decrees, and Orders.** (Applies to Premium Payment Benefits that Provide Accident or Health Coverage, and to Medical Care Reimbursement Benefits, but not to DCAP Benefit). If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former spouse) cover the Dependent child, you may change your election to revoke coverage for the child;

6. **Entitlement to Medicare or Medicaid.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits as limited below, but not to DCAP Benefits). If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage;

7. **Change in Cost.** (Applies to Premium Payment Benefits, to DCAP Benefits as limited below, but not to Medical Care Reimbursement Benefits). For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individual (e.g. family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage:

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

    b. Significant Cost Increases. If Archdiocese of St. Louis determines that the cost charged to you for your Plan significantly increases during a Period of Coverage, you may (a) make a corresponding prospective increase in your elective contributions (by increasing Salary Reductions); (b) revoke your election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Plan offered by Archdiocese of St. Louis that provides similar coverage, or (c) drop coverage prospectively if there is no other Plan option available that provides similar coverage. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidelines;

c. Significant Cost Decreases. If Archdiocese of St. Louis determines that the cost charged to you for your Plan significantly decreases during a Period of Coverage, Archdiocese of St. Louis may permit the following election changes: (a) Participants who are enrolled the Plan option other than the Plan option that has decreased in cost may change their election on a prospective basis to elect the Plan option that has decreased in cost; and (b) Employees who are otherwise eligible under Q-3 may elect the Plan option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Plan option. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidelines; and

d. Limitations on Change in Cost Provisions for DCAP Benefits. The above "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§152(a)(1) through 152(a)(8), incorporating the rules of Code §§152(b)(1) and 152(b)(2).

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, then Mike may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

8. **Change in Coverage.** (Applies to Premium Payment Benefits, and DCAP Benefits, but not to Medical Care Reimbursement Benefits). For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individual (e.g. family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage:

a. Significant Curtailment. If coverage is "significantly curtailed" (as defined in subsection (i) below, you may elect coverage under another plan that provides similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below), you may drop coverage if no similar coverage is offered by Archdiocese of St. Louis. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is "significant," and whether a Loss of Coverage has occurred:

i. Significant Curtailment Without Loss of Coverage. If Archdiocese of St. Louis determines that your coverage under this Plan (or your Spouse's or Dependent's coverage under the employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, you may revoke your election for the affected coverage, and in lieu of thereof, prospectively elect coverage under

another Plan option that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally;

ii. Significant Curtailment With a Loss of Coverage. If Archdiocese of St. Louis determines that your coverage under this Plan (or your Spouse's or Dependent's coverage under this employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, you may revoke his election for the affected coverage, and may either elect coverage under another Plan that provides similar coverage, or drop coverage if no other Plan option providing similar coverage is offered by Archdiocese of St. Louis; or

iii. Definition of Loss of Coverage. For the purposes of this section, a "Loss of Coverage" means complete loss of coverage (including the elimination of a Plan, the PPO ceasing to be available where you or his Spouse or Dependent resides, or you or your Spouse of Dependent losing all coverage under a Plan by reason of an overall lifetime or annual limitation). In addition, Archdiocese of St. Louis in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Plan (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a preferred provider network);

- a reduction in benefits for a specified type of medical condition or treatment with respect to which you or your Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

b. Addition or Significant Improvement of a Plan. If, during a Period of Coverage, the Plan adds a new benefit option or significantly improves an existing benefit option, Archdiocese of St. Louis may permit the following election changes:

i. Participants who are enrolled in a Plan option other than the newly-added or significantly improved benefit option may change their elections on a prospective basis to elect the newly-added or significantly improved benefit option; and

ii. Employees who are otherwise eligible under Q-3 may elect the newly-added or significantly improved benefit option on a prospective basis, subject to the terms and limitations of the Plan. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will

decide whether there has been an addition of, or a significant-improvement in a Plan option in accordance with prevailing IRS guidelines;

c. Loss of Coverage Under Other Group Health Coverage. You may prospectively change your election to add group health coverage for yourself or your Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(400)), the Indian Health Service, or tribal organization; a state health benefits risk pool, or a foreign government group health plan, subject to the terms and limitations of the applicable Plan(s);

d. Change in Coverage Under Another Employer Plan. You may make a prospective election change that is on account of and corresponds with a change under an employer plan (including a plan of the employer or a plan of your Spouse's or Dependent's employer), so long as: (a) the other cafeteria plan or qualified benefits plan permits it's participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election of a Period of Coverage that is different from the Plan Year under the cafeteria plan or qualified benefit plan. For example, if an election is made by your Spouse during your employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidelines; or

e. DCAP Coverage Changes. You may make a prospective election change that is on account and corresponds with a change by yourself in the dependent care service provider. For example: (a) if you terminate one dependent care provider and hire a new dependent care service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage;

If you are entitled to change an election as described in this section must do so in accordance with the procedures described in this section; or

9. **Prevent Discrimination.** Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-7. How are my Premium Payments Made?

If an Employee elects to pay his Insurance Plan premiums under the Premium Payment Component, then the Employee's share (as determined by the Employer) of the premium for the Insurance Plan(s) benefit(s) elected by the Participant will be financed by Salary Reductions. The Salary Reduction for each pay period for a Participant is an amount equal to the annual premium divided by the number of pay periods in the Plan Year, or an amount otherwise agreed upon. Salary Reductions are applied by the Employer to pay for the premium for the Participant's benefits and, for the purposes of this Plan, are considered Employer contributions. The Employer will pay under this Plan its share of the premiums for Participants who elect to participate in the pre-tax feature of this Plan. For those who elect the after-tax option, both the Employee and Employer portions of the premiums will be paid outside of this Plan.

Q-8. What if I terminate my employment during the Plan Year or I lose eligibility for other reasons?

If your employment with Archdiocese of St. Louis is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See the insurance booklets for information on your right to continued or converted coverage after termination of your employment. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections will remain in effect for the remainder of the Plan Year.

If you cease to be an eligible Employee for reasons other than termination, such as a reduction in hours, you must complete the waiting period described in Q-3 before again becoming eligible to participate in the plan.

Q-9. Will I pay any administrative costs under the Plan?

Archdiocese of St. Louis is currently bearing the entire cost of administering the Plan.

Q-10. How long will the Plan remain in effect?

Although Archdiocese of St. Louis expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if a claim for benefits is denied?

Insurance Plan Coverage Claims. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedure applicable under the component Benefit Plan or Policy.

Claims Under the Plan. If a claim for reimbursement under the Medical Reimbursement Component or the DCAP is wholly or partially denied, or if the Participant is denied a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to the Participant's coverage under this Plan (such as a determination of a Change in

Status, a "significant" change in premiums charged, or eligibility and participation matters under the Flexible Benefits Plan document), then the claims procedure described below will apply.

The payment of any benefit set forth herein is subject to the provision that the Participant furnish such proof and releases as the Administrator may reasonably require before approving the payment of any such benefit.

If the Administrator determines that a claim should be denied in whole or in part, written notice will be given to the Participant within a reasonable period of time after receipt of the claim. The written notice will list:

1. The reasons for denial;

2. The plan provisions on which denial is based;

3. A description of additional information which may be necessary;

4. An explanation of how the claim may be reviewed.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) which are based on taxable compensation.

Q-13. What is the Family and Medical Leave Act?

If your Administrator is subject to the Family and Medical Leave Act (FMLA) (generally, employers with at least 50 employees are subject to such) and if you are on eligible leave under FMLA, then you may continue to pay for your Health Insurance coverages on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis via extra salary reductions before you go on leave). If your Administrator pays a portion of your Health Insurance premiums, then it must continue those payments. However, if you do not return from FMLA, you may be required to repay Archdiocese of St. Louis-paid portion of the Health Insurance premiums. If your Administrator is subject to FMLA, then you should be provided with a complete explanation of your FMLA rights and responsibilities.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

If the Participant's Employer is subject to the Family and Medical Leave Act (FMLA) (generally, employers with at least 50 employees are subject to such) and if the Participant is on eligible leave under FMLA, then the Participant may continue to pay for his Insurance Plan and Medical Reimbursement Component coverage on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis via extra Salary Reductions before the leave commences). If the Participant's Employer pays a portion of the Participant's Insurance Plan premiums, then it must continue those payments. However, if the Participant does not return from FMLA, the Participant may be required to repay Employer-paid portion of the Insurance

Plan premiums. If the Participant's Employer is subject to FMLA, then the Participant should be provided with a complete explanation of his FMLA rights and responsibilities.

FMLA Leaves of Absence. If the Participant goes on a qualifying leave under the FMLA, to the extent required by the FMLA, the Participant's Employer will continue to maintain the Participant's Insurance Plan benefits and Medical Care Reimbursement Benefits on the same terms and conditions as if the Participant were still active (that is, his Employer will continue to pay its share of the premium to the extent the Participant opts to continue coverage). The Employer may elect to continue all Insurance Plan benefits and Medical Care Reimbursement Benefits for Participants while they are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant will pay his share of the premiums by the method normally used during any paid leave (for example, on a pre-tax Salary Reduction basis if that is what was used before the FMLA leave began).

If the Participant is going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and the Participant opts to continue his Insurance Plan benefits and Medical Care Reimbursement Benefits, then the Participant may pay his share of the premium in one of three ways:

1. With after-tax dollars while on leave;

2. With pre-tax dollars to the extent the Participant receives Compensation during the leave, or by pre-paying all or a portion of the Participant's share of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of the Participant's pre-leave Compensation, including unused sick days and vacation days. To pre-pay, the Participant must make a special election before such Compensation would normally be available to the Participant (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or

3. By other arrangements agreed upon between the Participant and the Administrator (for example, the Administrator may pay for coverage during the leave and withhold amounts from the Participant's Compensation upon his return from leave).

If the Employer requires all Participants to continue Insurance Plan benefits and Medical Care Reimbursement Benefits during the unpaid leave, the Participant may discontinue paying his share of the required premium until the Participant returns. Upon returning from leave, the Participant must pay his share of any required premiums that the Participant did not pay during the leave. Payment for the Participant's share will be withheld from his Compensation on either a pre-tax basis or an after-tax basis, as the Participant and the Administrator may agree.

If the Participant's Insurance Plan benefits or Medical Care Reimbursement Benefits cease while on FMLA leave (e.g. for non-payment of required contributions), the Participant will be entitled to resume such Insurance Plan benefits and Medical Care Reimbursement Benefits, as applicable, upon return from such leave on the same basis as he was participating in the Plan before the leave, or otherwise required by the FMLA. The Participant is entitled to have coverage for such Insurance Plan benefits and Medical Care Reimbursement Benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon returning from leave. But, despite the preceding sentence, with regard to

Medical Care Reimbursement Benefits, if the Participant's coverage ceased, he will be entitled to elect whether to be reinstated in the Medical Care Reimbursement Benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining Period of Coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premiums. If the Participant elects the pro-rata coverage, the amount withheld from his Compensation on a payroll-to-payroll basis for the purpose of paying for reinstated Medical Care Reimbursement Benefits will equal the amount withheld before FMLA leave.

Non-FMLA Leaves of Absence. If the Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, after-tax contributions while on leave, or catch-up contributions after the leave ends, as may be determined by the Administrator.

Q-15. What are Medical Care Expense Reimbursement Benefits?

Under the Medical Care Reimbursement component, you purchase a specific level of Medical Care Reimbursement benefits, paying for coverage through a Salary Reduction Agreement with Archdiocese of St. Louis, in lieu of a corresponding amount of current pay, which means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the plan for certain eligible Medical Expenses. This arrangement helps you because the level of coverage you elect is non-taxable; thereby saving you social security and income taxes on the amount of the premiums you pay.

Q-16. What is my "Medical Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a Medical Care Reimbursement Account will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year. Your Medical Care Reimbursement Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the employer).

Q-17. What annual benefits are available under the Medical Reimbursement component, and how much will they cost?

The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Plan Year will be the current IRS Allowable Maximum, which is $3,050 for 2023. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Plan Year shall be $1. Amounts received that are attributable to reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be attributed to the Participant. For subsequent Plan Years, the maximum and minimum annual benefit amount may be changed by the Administrator and shall be communicated to Employees via the Enrollment Form, via another document, or via the Online Enrollment Form. If a Participant enters the Plan mid-year, then the annual maximum amount of benefit may be prorated for the first partial year of participation.

Q-18. How is my Medical Care Expense Reimbursement benefit paid?

The annual premium for a Participant's benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $3,050 annual benefit amount is elected, then the annual premium amount is also $3,050). The Salary Reduction for each pay period for a Participant is an amount equal to the annual premium divided by the number of pay periods in the Plan Year, or an amount otherwise mutually agreed upon. Salary Reductions are applied by the Employer to pay for the premium for the Participant's benefits and, for the purposes of this Plan, are considered Employer contributions.

Q-19. What amounts will be available for Medical Care Expense Reimbursement Plan at any particular time during the Plan Year?

Provided that you have continued to contribute the periodic amounts for this benefit, the full, annual amount of coverage you have elected will be available at any time during the Plan Year, although reduced by the amount of prior reimbursements received during the year.

Q-20. How do I receive reimbursement under the Plan?

Expenses That May Be Reimbursed. Under the Medical Reimbursement Component, a Participant may receive reimbursement for Medical Care Expenses incurred while he is a Participant during the Plan Year for which an election is in force. A medical expense is incurred at the time the medical care or service giving rise to the expense is furnished.

Maximum Reimbursement Available. Reimbursement for Medical Care Expenses of the maximum dollar amount elected by the Participant for a Plan Year (reduced by prior reimbursements during the Plan Year) shall be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's Medical Reimbursement Account. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Plan has terminated, unless the Participant has elected continuation coverage.

Timing of Reimbursement. As soon as is practical after the Participant submits a reimbursement claim to the Administrator, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approved the claim), or the Administrator will notify the Participant that his claim has been denied.

Use-It-or-Lose-It Rule. If a Participant does not submit enough expenses to receive reimbursements for the full amount of coverage elected for a Plan Year, then the excess amount will be forfeited and applied by the Employer.

Applying for Reimbursements. A Participant can submit a paper claim, including the receipt, to TRISTAR Benefit Administrators for reimbursement. You must include written statement(s)/bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s) along with a TRISTAR Benefit Administrators claim form.

1. Complete the Flexible Benefits Plan Reimbursement claim form. This form is available

from your employer or from TRISTAR Benefit Administrators; and

2. Submit documentation of the expense by mailing, faxing, or emailing it to TRISTAR Benefit Administrators.

Mailing Address:	TRISTAR Benefit Administrators 5820 S. Eastern Avenue, Suite 250 Las Vegas, NV 89119
Fax Number:	702-216-1623
Email Address:	flex@tristargroup.net

Account balance information is available online at tristar.summitfor.me . You may also file a claim online through this website.

You will have until December 15th following the end of the Plan Year and Grace Period in which to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year and Grace Period. You will be notified in writing if any claim for benefits is denied.

Q-21. What are "Medical Care Expenses" that may be reimbursed from the Medical Care Reimbursement?

Under the Medical Care Reimbursement component, you purchase a specific level of Medical Care Reimbursement benefits, paying for coverage through a Salary Reduction Agreement with Archdiocese of St. Louis in lieu of a corresponding amount of current pay, which means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the plan for certain eligible Medical Expenses. This arrangement helps you because the level of coverage you elect is non-taxable; thereby saving you social security and income taxes on the amount of the premiums you pay.

For purposes of the Medical Care Reimbursement Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d).

The following expenses are eligible for reimbursement under the Medical Reimbursement Coverage:

Acupuncture.

Ambulance.

Chiropractic related services.

Deductible, coinsurance, and co-payments.

Dental fees - exams, fillings, x-rays, dentures, orthodontic fees, etc. For orthodontic services, payment can only be considered for services actually performed during the Plan Year, including the initial placement fee, and monthly adjustment fees, and not the total orthodontia fee

Hearing aids and batteries.

Laser surgery for vision improvement.

Learning disability - Tutoring by licensed school or therapist as recommended by a physician.

Massage Therapy (if prescribed by a Physician and if a letter of medical necessity is provided).

Medical fees such as x-ray and laboratory services.

Menstrual care products such as liners, pads, tampons, and cups.

Over-the-counter items such as allergy and sinus treatment, pain relief items, cold and flu medicine, Covid tests, denture adhesive and cleaners, diaper rash ointments and creams, gastrointestinal medication, adult incontinence supplies, laxatives, nasal spray, nasal strips, toothache and teething pain relievers and wart removal treatments.

Personal Protective Equipment (PPE) such as face masks and hand sanitizer.

Physical Therapy or Occupational Therapy by a licensed therapist.

Physician fees.

Psychotherapy and psychoanalysis provided the expenses are for medical care.

Special schools to relieve a handicapped condition.

Vaccinations and immunizations.

Transportation expenses, if the expenses are primarily for and essential to medical care.

Vision care - Eye Exams, Eyeglasses, Contact lenses, and contact lens solution.

Weight loss programs and/or drugs prescribed to induce weight loss, provided the program is prescribed by a doctor to treat an existing disease (e.g. obesity, heart disease, or diabetes), and is not simply to improve general health.

Wheelchairs-includes rental or purchase.

The following expenses are NOT eligible for reimbursement under a Medical Care Expense Reimbursement Plan:

Abortion related services.

Any item that does not constitute “medical care” as defined under Code § 213.

Any item that is not reimbursable under Code § 213 due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.

Automobile insurance premiums.

Bottled water.

Contraceptives, including, but not limited to oral contraceptives, contraceptive devices (i.e. diaphragms, IUD’s), contraceptive injectionables (e.g. Depo-Provera), or contraceptive implants (i.e. Norplant).

Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Cosmetics, toiletries, toothpaste, etc.

Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods.

Custodial care.

Diaper service or diapers.

Foods associated with a weight loss program.

Funeral and burial expenses.

Health club dues, or fitness programs.

Health insurance premiums.

Home or automobile improvements.

Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).

In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, or other artificial fertilization procedures.
Long-term care services.

Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

Social activities, such as dance lessons, even if recommended by a qualified physician for general health improvement.

Maternity clothes.

Salary expense of a nurse to care for a healthy newborn at home.

Sterilization, tubal ligation, or vasectomy.

Uniforms or special clothing.

For more information about what items are - and are not - Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Medical Care Reimbursement. In fact, some of the statements in the Publication are not correct when determining whether that same expense is reimbursable from your Medical Care Reimbursement. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Medical Care Reimbursement (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Medical Care Reimbursement. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally, they cannot be reimbursed from your Medical Care Reimbursement.) Not all expenses that are reimbursable under a Medical Care Reimbursement are deductible. (For example, Medical Care Reimbursements may reimburse OTC drugs if they qualify as medical care under Code § 213(d), but they are still not deductible under Code §§ 213(a) and 213(b).)

Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-22. When must the expenses be incurred?

Medical Expenses must be incurred during the 14 1/2 month period that starts at the beginning of the Plan Year and ends on the 15th of the third month after the end of the Plan Year (e.g. if the Plan Year is July 1 to June 30, claims must be incurred no later than September 15. The period from July 1 to September 15 is called the "Grace Period") A medical expense is incurred when the service that gives rise to the expense is provided; when the expense is paid is irrelevant. You may not be reimbursed for any expenses arising before the Plan became effective, before your Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage).
You will have until December 15th following the end of the Plan Year and Grace Period to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year and the Grace Period. You will be notified in writing if any claim for benefits is denied.

Q-23. What if the Medical Expenses I incur during the Plan Year and Grace Period are less than the annual amount I have elected for Medical Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual medical expenses you have incurred and the annual coverage level you have elected and paid for. Any amount allocated to an Account will be forfeited by the Participant and be used as provided in the Plan, if it has not been applied to the elected benefit for any Plan Year by December 15th following the end of the Plan Year and Grace Period, for which the election was effective. Amounts forfeited will be used to offset administrative expenses and future costs.

Q-24. Forfeiture of Unclaimed Reimbursement Account Benefits

Any Medical Care Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year and Grace Period following the Plan Year and Grace Period in which the expense was incurred will be forfeited.

Q-25. What are Dependent Care Expense Reimbursement (DCAP) Benefits?

Under the Dependent Care Assistance Program (DCAP) component, you provide a source of pre-tax funds to reimburse yourself for your Eligible DCAP Expenses by entering into a Salary Reduction Agreement with your Administrator under which you agree to a salary reduction to fund DCAP Expenses in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is non-taxable, thereby saving you social security and income taxes on the amount of your salary conversion.

Q-26. What is my "DCAP Expense Reimbursement Account"

Under the DCAP Component of this Plan, Participant may elect to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses and to pay the premium for such benefits via Salary Reductions.

Q-27. What is the maximum DCAP benefit I may elect?

The maximum annual benefit amount that you may elect to receive under this Plan in the form of reimbursements for Eligible Employment-Related Expenses incurred in any Plan Year and Grace Period is $5,000. Because the Plan year and Calendar year are different, it is important to make sure you do not incur more than $5,000 in any Calendar year. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Eligible Employment-Related Expenses incurred in any Plan Year shall be $1. For subsequent Plan Years, the maximum and minimum annual benefit amount may be changed by the Administrator and shall be communicated to Employees via the Enrollment Form, via another document, or via the Online Enrollment Form. If a Participant enters the Plan mid-year, then the annual maximum amount of benefit will be prorated for the first partial year of participation.

Q-28. How is my DCAP Expense benefit funded?

When you complete the Salary Reduction Agreement, you specify the amount of DCAP benefits for which you wish to pay with your salary reduction. Thereafter, your DCAP Reimbursement Account will be credited with the portion of your gross income that you have elected to forgo through salary reduction. These portions will be credited as of each pay period. The amount that is available for reimbursements at any particular time will be whatever has been credited to your DCAP Reimbursement Account, less any reimbursements already paid.

For example, suppose you have elected to be reimbursed for $2,600 per year for DCAP Expenses, and you have chosen no other benefit under the Employer's Cafeteria Plan. Your DCAP Reimbursement Account would be credited (and funded) with a total of $2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of $100 credited to your DCAP Reimbursement Account each payday to pay reimbursements under this Plan.

Q-29. What is an "Eligible DCAP Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses incurred on behalf of any individual in your family who is under age 13, and whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically incapable of caring for himself or herself, or your Spouse, if the Spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet *all* of the following conditions for them to be Eligible DCAP Expenses:

1. The expenses are incurred for services rendered after the date of your election to receive DCAP Expense Reimbursement, and during the calendar year to which it applies;

2. Each individual for whom you incur the expense is:

    a. a Dependent under age 13 whom you are entitled to a personal tax exemption as a dependent, or

    b. a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself;

3. The expenses are incurred for the care of a Dependent (as described above) or, for related household services, and are incurred to enable you to be gainfully employed;

4. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is under age 13, such Dependent regularly spends at least 8 hours per day in your home;

5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations;

6. The expenses are not paid or payable *to* a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent;

7. This reimbursement (when aggregated with all other DCAP Reimbursements during the same year) may not exceed the least of the following limits:

    a. $5,000;

    b. $2,500 if you are married, but you and your Spouse files separate tax returns;

    c. your taxable compensation (after your salary reduction under the Flexible Benefits Plan); or

    d. if you are married, your Spouse's actual or deemed Earned Income;

For this purpose, expenses are incurred when the services giving rise to the expenses have been rendered; when you pay for the expense is irrelevant. For purposes of (D) above, your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more dependents described in paragraph 2 above), for each month in which your spouse is:

1. Physically or mentally incapable of self-care, or

2. A full-time student.

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 Eligible Expense if you have any doubts.

Q-30. What amounts will be available for DCAP Expense Reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of DCAP Expenses at any particular time during the Plan Year and Grace Period will be equal to the amount credited to your DCAP Expense Reimbursement Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year and Grace Period.

Q-31. How do I receive a DCAP Expense Reimbursement under the Plan?

Timing of Reimbursement. As soon as practical after the Administrator receives a reimbursement claim from the Participant, the Employer will reimburse the Participant for the Participant's Eligible Employment-Related Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his claim has been denied.

Use-It-or-Lose-It Rule. If a Participant does not submit enough expenses to receive reimbursements for the full amount of coverage elected for a Plan Year and Grace Period, then the excess amount will be forfeited and applied by the Employer.

Applying for Reimbursements. The Participant must submit a claim to TRISTAR Benefit Administrators on a Claim Form that will be supplied. If there is enough money in your Dependent Care Expenses Reimbursement Account, you will be reimbursed for the eligible expenses during the next scheduled reimbursement period.

If a claim is for an amount that is more than your current Dependent Care Reimbursement Account balance, then the excess part of the claim will be carried over into the next reimbursement period, to be paid out as the balance becomes adequate. You will not be reimbursed for any expenses that arise before the Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year and Grace Period.

To have your claims processed as soon as possible, you should read the claims instructions. It is not necessary for you to have actually paid an amount due for Dependent Care Reimbursement Account Expenses-only for you to have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. Note that if you have paid for the expense but if the services have not yet been rendered, the expense has not been incurred for this purpose. For example, if you pay for your child's day care on the first day of the month for care given during that month, the expense has not been incurred until the end of that month.

In addition, you will have until December 15th , following the Plan Year and Grace Period in which to submit a claim for reimbursement for Dependent Care Reimbursement Account Expenses incurred during the previous Plan Year and Grace Period. You will be notified in writing if any claim for benefits is denied.

For this purpose, Eligible Employment-Related Expenses have been incurred when the services giving rise to the expenses have been rendered.

Q-32. What if the Eligible Employment Related DCAP Expenses I incur during the Plan Year and Grace Period are less than the annual amount of coverage I have elected for DCAP Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related DCAP Expenses you have incurred, on the one hand, and the annual coverage you have elected and paid for, on the other. Any amount allocated to an Account will be forfeited by the Participant and restored to Archdiocese of St. Louis if it has not been applied to provide the elected reimbursement for any Plan Year by December 15th following the end of the Plan Year and Grace Period for which the election was effective. Amounts so forfeited will be used to offset reasonable administrative expenses and future costs.

Q-33. Will I be taxed on the DCAP benefits I receive?

You will not normally be taxed on your DCAP benefits, up to the limits set out in Q-30 of this summary. However, to qualify for tax-free treatment, you will be required to file IRS Form 12441 or a similar form listing 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.

Q-34. If I participate in the DCAP, 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 this Plan, although the *balance* of your Dependent Care Expenses may be eligible for the dependent care credit under Code § 21 (Dependent Care Credit) (e.g., if you elect $3,000 of coverage under the DCAP and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5.000, you could count the excess $2,000 when calculating the Dependent Care Credit if you have two or more dependents). Note: the amount of any Dependent Care Credit you may have available will be offset by any DCAP Benefits received under the plan.

Q-35. What is the Dependent Care Credit?

The Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability under the Code. In determining what the tax credit would be for the current year, you may take into account $3,000 of such expenses for one dependent, or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 (for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents). The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

Illustration: Assume that in the current year, you have one dependent for which you have incurred dependent care expenses of $3,600, and that your adjusted gross income is $20.000. Since only one dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more dependents, your credit would have been $3,600 x 32% = $1,152, because the entire expense would have been taken into account, not just the first $2,400.

For more information about how the Dependent Care Credit works, see IRS Publication Number 503 (“Child and Dependent Care Expenses”). You may also wish to consult a tax advisor.

Q-36. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in one of the lower income tax brackets, you might come out ahead by not participating in the DCAP and by claiming the Dependent Care Credit instead. On the other hand, generally the more income taxes you are required to pay, the better it would be tax-wise to participate in the DCAP. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you. You may also wish to consult a tax advisor.

Q-37. Forfeiture of Unclaimed DCAP Expense Reimbursement Account Benefits

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year and Grace Period in which the DCAP Expense was incurred will be forfeited.

Q-38. Reimbursements after Termination.

When a Participant ceases to be a Participant as defined under Q-3, the Participant's Salary Reductions will terminate, as will his election to receive reimbursements. However, the Participant will be able to receive reimbursements for Eligible Employment-Related Expenses incurred during the Plan Year before his participation terminates, as long as the claims for reimbursement are submitted within 167 days following the end of the Plan Year in which the expense arose.

Q-39. What is the Privacy Policy?

Commitment to Protecting Health Information

This Flexible Benefits Plan ("Plan") will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the plan participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The plan participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;

2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose *PHI* other than as permitted or required by the *Plan Document*s or as required by law (as defined in the *privacy standards*);
- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;
- Not use or disclose *PHI* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor*, except pursuant to an authorization which meets the requirements of the *privacy standards;*
- Notify *participants* of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Notify the Federal Trade Commission of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Report to the *Plan* any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services *("HHS"),* or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);
- Obtain authorization prior to the sale of any *PHI*;
- If feasible, return or destroy all *PHI* received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such *PHI* when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the *PHI* infeasible; and

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - Only employees, or classes of employees, or other persons under control of the *Plan S*ponsor designated as such by *Plan Sponsor* and listed below at the end of this Section, shall be given access to the *PHI* to be disclosed.
  - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.
  - In the event any of the individuals described in above do not comply with the provisions of the *Plan Document*s relating to use and disclosure of *PHI*, the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the *Plan* or solicit bids from prospective issuers. *"Plan administration"* functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan Document*s have been amended to incorporate the above provisions; and
- The *Plan Sponsor* agrees to comply with such provisions.

<u>Disclosure of Summary Health Information to the Plan Sponsor</u>

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids from health plans for providing health insurance coverage under this Plan; or modifying, amending, or terminating the Plan.

The *Plan* is prohibited from using or disclosing genetic information for underwriting purposes, such as determining eligibility or determination of benefits, computation of premium or contribution amounts, and other activities related to the creation, replacement, or renewal of a contract of health insurance or health benefits.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan*, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the *privacy standards* (45 CFR 164.504(f)(1)(iii)), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor.*

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party administrator,* to disclose *PHI* to stop-loss carriers, excess loss carriers or managing general underwriters *("MGUs")* for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures shall be made in accordance with the *privacy standards*.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment, and Health Care Operations: The Plan has the right to use and disclose a plan participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the plan participant's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    a. a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
c. locate and notify persons of recalls of products they may be using; and
d. a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the plan participant's agreement, if the Plan reasonably believes him/her to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative, or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the plan participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the plan participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director, or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a plan participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the plan participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the plan participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the plan participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends, or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a

certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the plan participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the plan participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

<u>Questions or Complaints</u>

If the Plan Participant wants more information about the Plan's privacy practices, has questions, or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

GENERAL INFORMATION ABOUT THE PLAN

Plan Name:	Archdiocese of St. Louis Flexible Benefit Plan
Plan Number:	501
Effective Date:	July 1, 2003
Plan Year:	July 1 through June 30

Employer Name and Address

Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119-5004

Employer Federal Tax Identification Number

43-0653244

Plan Administrator Name, Address, and Telephone Number

Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119-5004
314-792-7540

Archdiocese of St. Louis appoints a Committee that keeps the records for the Plan and is responsible for the administration of the Plan. The Committee will also answer any questions you may have about your Plan. You may contact the Committee at the above address for any further information about the Plan.

Service of Legal Process

Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119-5004
Attention: Flexible Benefits Plan Committee

Claims Administrator

TRISTAR Benefit Administrators
5820 S. Eastern Avenue, Suite 250
Las Vegas, NV 89119
800-456-4584

ARCHDIOCESE OF ST. LOUIS FLEXIBLE BENEFITS PLAN CLAIM FORM

PLEASE READ THE GUIDELINES FOR ELIGIBLE REIMBURSEMENTS ON THE REVERSE SIDE

1. Employee Information: Complete all sections.				
Employer Information	Parish/Agency Employer Name			
Employee Information ☐ Check box if new address.	Employee's Last Name	First Name	Initial	Employees Social Security No. - -
	Home Address			
	City	State	Zip	Daytime Phone Number

2. Health Care: An itemized statement is required including date of service, type of service, and total charge.

Please check one of the following boxes:

☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. Enclosed is an Explanation of Benefits from my insurance. An Explanation of Benefits is required even if charges are applied to your deductible or out-of-pocket liability.

☐ Charges are **not** a covered benefit by any insurance plan for which the patient is enrolled.

☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. My insurance company does not provide an Explanation of Benefits for these services. Enclosed is an itemized receipt provided by the provider of service.

Date (s) Incurred	Name of Person Receiving Care	Description of Expense	Provider Name (i.e., clinic, doctor, hospital)	Total Expense	Amt. Paid by Insurance	Amount Remaining
			TOTAL AMOUNT OF MEDICAL EXPENSE	$	$	$

3. Dependent Care: A receipt is required from your daycare provider that includes dates of care and total charge. If you do not have a receipt, the daycare provider must sign verification section.

Dependent Receiving Care Name	Relationship	Age	Date(s) of Care	Care Provider (Name and Soc. Sec. No./Federal Tax ID)	Amount

DAYCARE PROVIDER VERIFICATION: I certify that the expenses shown are valid.

Signature _____ Soc. Sec. No. / Federal Tax ID _____ Date _____

4. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I receive reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical and/or dependent care expenses, which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and as outlined on the reverse side of this form. I certify that none of the medical reimbursements are for items (including contraceptives, sterilization, and abortion) contrary to the Doctrine of the Catholic Church.

Employee's Signature	Date / / Mo. Day Year

Please send the completed claim form and appropriate statements to:

TRISTAR BENEFIT ADMINISTRATORS
5820 S. Eastern Avenue, Suite 250
Las Vegas, NV 89119
(800) 456-4584
Email: Flex@tristargroup.net Fax#: 702-216-1623

GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

PLEASE MAKE A COPY OF ALL ENCLOSURES FOR YOUR PERSONAL REFERENCE/INCOME TAX RECORDS.

If you have not submitted the medical and/or dental expense to your insurance plan(s), please do so prior to submission on this Flexible Spending Account Reimbursement form.

If you apply for reimbursement of expense that IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement for expenses that have already been reimbursed from some other source.

In general, Section 125 of the Internal Revenue Code governs the tax status of Flexible (or Cafeteria) Benefit Plans, of which Employee Reimbursement Accounts are a part. Eligibility for pre-tax reimbursement is covered specifically in Code Sections 105 and 106 (Accident/Health Plans) and Section 129 (Dependent Care).

MEDICAL REIMBURSEMENT

Generally, any expense that is allowed under IRS Code § 213 is eligible except as shown in the SPD. Please refer to your Flexible Benefit Plan SPD for details

Acupuncture.
Ambulance.
Chiropractic related services.
Deductible, coinsurance, and co-payments.
Dental fees - exams, fillings, x-rays, dentures, orthodontic fees, etc. For orthodontic services, payment can only be considered for services actually performed during the plan year, including the initial placement fee, and monthly adjustment fees, and not the total orthodontia fee
Items used by individuals with respect to menstruation including tampons, pads, liners, cups, sponges, or other similar products.
Hearing aids and batteries.
Laser surgery for vision improvement.
Learning disability - Tutoring by licensed school or therapist as recommended by a physician.
Massage Therapy (if prescribed by a Physician and if a letter of medical necessity is provided).
Medical fees such as x-ray and laboratory services.
Menstrual care products such as liners, pads, tampons, and cups.
Over-the-counter items such as allergy and sinus treatment, pain relief items, cold and flu medicine, Covid tests, denture adhesive and cleaners, diaper rash ointments and creams, gastrointestinal medication, adult incontinence supplies, laxatives, nasal spray, nasal strips, toothache and teething pain relievers and wart removal treatments.
Personal Protective Equipment (PPE) such as face masks and hand sanitizer.
Physical Therapy or Occupational Therapy by a licensed therapist.
Physician fees.
Psychotherapy and psychoanalysis provided the expenses are for medical care.
Special schools to relieve a handicapped condition.
Vaccinations and immunizations.
Transportation expenses, if the expenses are primarily for and essential to medical care.
Vision care - Eye Exams, Eyeglasses, Contact lenses, and contact lens solution.
Weight loss programs and/or drugs prescribed to induce weight loss, provided the program is prescribed by a doctor to treat an existing disease (e.g. obesity, heart disease, or diabetes), and is not simply to improve general health.
Wheelchairs – includes rental or purchase.

DEPENDENT CARE REIMBURSEMENT

Expenses to provide care for your dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a disabled parent.

To be eligible, you must be working while your dependents receive care, or if you are married, your spouse must be:

1. A wage earner,
2. A full-time student for at least 5 months during the year, or
3. A disabled and unable to provide for his or her own care.

Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:

1. Licensed nursery schools and licensed day care centers.
2. Individuals - other than your dependents - who provide care for your children in or outside your home or for your disabled spouse or dependent parent in your home.
3. Housekeepers, maids, or cooks in your home, to include their food and lodging in your home, as long as their services are performed for the benefit of your eligible dependent(s).

IRS Regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned Income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns $200 per month (one dependent) or $400 per month (two or more dependents).

An additional IRS Regulation limits the amount you can contribute to the dependent care account to $5,000 for a single parent with children, $5,000 for a married parent filing jointly, and $2,500 for a married parent filing separately. This amount may change with IRS regulations.

Under IRS Regulations, qualified individuals can receive tax credit for dependent care costs. This credit is claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by any amount you use from the Dependent Care Reimbursement Account.

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