MASTER DOCUMENT

City of Burleson

SECTION 125 CAFETERIA PLAN

Effective as Amended and Restated January 1, 2020

City of Burleson

SECTION 125 CAFETERIA PLAN

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INTRODUCTION

The City of Burleson Flexible Benefit Plan was adopted effective January 1, 2016 by City of Burleson for the benefit of its Employees. This amended and restated plan is adopted effective January 1, 2020.

The purpose of the Plan is to enable Employees who become covered under the Plan to elect payment of premiums for various coverages in lieu of cash compensation. With respect to benefit coverages, this Plan only concerns Premium Expenses and/or flexible spending account benefits. This Plan has no effect on the benefits or claim payments made under each benefit plan or area of benefit coverage.

The Plan is intended to qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and comply with any other applicable provisions of law, including without limitation, Sections 105 and 106 of the Code.

ARTICLE I

DEFINITIONS

The following terms when used herein shall have the following meanings, unless a different meaning is plainly required by the context. Capitalized terms are used throughout the Plan text for terms defined by this and other sections.

1.01 Agreement means the agreement executed by the Company pursuant to Article IX whereby such Company adopts the Plan.

1.02 Change in Status means any of the events described under Code Section 125 and the regulations issued thereunder, as well as any subsequent changes to the Code or such regulations and interpretations thereof, that the Plan administrator, in its sole discretion, recognizes on a uniform and consistent basis, including the following:

(a) Legal Marital Status: Events that change an Employee's legal marital status, including marriage, death of a Spouse, divorce, legal separation, and annulment.

(b) Number of Dependents: Events that change an Employee's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) Employment Status: Any of the following events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the Employer of the Employee, Spouse, or Dependent

depend on the employment status of that individual and there is a change in the individual's employment status with the consequence that the individual becomes, or ceases to be, eligible under that plan, then that change constitutes a change in employment under this section of the Plan. For example, if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status under this section of the Plan.

(d) Dependent Eligibility Requirements: Events that cause an Employee's Dependent to satisfy, or cease to satisfy, eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) Residence: A change in the place of residence of the Employee, Spouse, or Dependent.

(f) Adoption Assistance. For purposes of adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

The "Changes of Benefit Elections" section of this Plan in Article IV sets out the requirements that must be met in order for an Employee to change his or her election during a Coverage Period on account of a Change in Status.

1.03 Code means the Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings pertaining to such section and shall also be deemed a reference to comparable provisions of future laws.

1.04 Committee means the individual or individuals appointed by the Company to carry out the administration of the Plan. In the event the Committee has not been appointed, or resigns from a prior appointment, the Company shall be deemed to be the Committee.

1.05 Company means City of Burleson that has adopted this Plan and any successor thereto. The Company is the sponsor and the administrator of the Plan.

1.06 Compensation means the total cash remuneration received by a Participant from the Employer during a Coverage Period prior to any reductions pursuant to an Enrollment Form authorized hereunder and prior to any salary reduction pursuant to any of the following: (a) another cafeteria plan; (b) a Code Section 132(f)(4) plan; or (c) a Code Section 401(k), 403(b), 408(k), or 457(b) plan or arrangement, as may be applicable.

1.07 Coverage Period means the Plan Year, provided that, for any Employee who becomes a Participant after the start of a Plan Year, the initial Coverage Period shall mean the period commencing on the effective date of such Participant's participation and extending through the remainder of the Plan Year.

1.08 Dependent means a Participant's Spouse, or a Participant's child(ren) who meet the definition of Code Section 152, and any other person meeting the definition of Code Section 152 who are eligible to receive benefits hereunder in accordance with the Enrollment Form. Notwithstanding the above, for purposes of any benefit hereunder that is also an accident and health plan as described in Code Section 105, whether a Participant's child(ren) or any other person (excluding a Spouse) meets the definition of Code Section 152 shall be determined without regard to Section 152(b)(1) (generally having to do with the inability of a person claimed as a dependent, to claim others as the person's dependent; i.e., dependent cannot have dependents), Section 152(b)(2) (generally having to do with joint returns by spouses), and Section 152(d)(1)(B) (generally having to do with gross income limitations for a qualifying relative), in accordance with the Working Families Tax Relief Act of 2004. For purposes of any dependent care expenses, Dependent shall have the meaning as defined in Code Section 152, except that in the case of such a Dependent who is a qualifying relative, or in the case of a Spouse, such Dependent or Spouse must be physically or mentally incapable of caring for himself or herself, and such Dependent or Spouse must have the same principal place of abode as the taxpayer for more than one-half of the taxable year. Further, in the event that the IRC is amended, such as a technical correction to address a potentially unintended impact of the Working Families Tax Relief Act of 2004 on the definition of "dependent" for purposes of IRC Section 129 for Dependent Care Assistance Programs, including IRC Section 21, or for any other purpose, the definition of Dependent herein shall automatically change along with such IRC amendment, without additional action to this Plan, to conform with such IRC amendment. Effective March 30, 2010, and in addition to the foregoing, the term Dependent shall include a Participant's children who are adult children until the individual child attains 26 years of age, as required by Section 2714 of the Public Health Services Act.

1.09 Effective Date of this amended and restated plan means January 1, 2020, or such later date an adopting Employer adopts the Plan for its Employees.

1.10 Election Period means the period designated by the Company, and communicated to Employees in advance, preceding each Coverage Period during which Participants may make elections under the Plan (except for any Employee who first becomes eligible to be a Participant during a Coverage Period, in which case section 4.03 shall apply). Such Election Period shall be a period of no less than two (2) weeks.

1.11 Employee means any person employed by the Employer who is eligible to receive a benefit under this Plan for which the Employee must pay Premium Expenses. The term shall specifically exclude self-employed individuals described in Code Section 401(c).

1.12 Employer means the Company and any other employer that adopts this Plan pursuant to section 6.01.

1.13 Employer Credit Contribution means any amount which the Employer, in its sole discretion, may contribute on behalf of Participants toward benefits under the Plan. The amount of the Employer Credit Contribution, if any, will be disclosed in Participant enrollment materials. The Employer Credit Contribution will be limited as designated in the enrollment materials. Except as otherwise provided in the enrollment materials, no Employer Credit Contribution will be disbursed to a Participant in cash, and any unused contributions shall be returned to the Employer.

1.14 Enrollment Form means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation in exchange for a qualified benefits plan as permitted under Section 125 of the Code, to the extent such benefit is offered under this Plan, and to have an equivalent amount contributed by the Employer for the purchase of the benefit elected by the Participant. The Enrollment Form shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the Enrollment Form (after taking this Plan into account) and subsequently does not become currently available to the Participant.

1.15 Participant means any Employee who becomes a Participant pursuant to Article II.

1.16 Plan means the City of Burleson Section 125 Cafeteria Plan.

1.17 Plan Administrator means City of Burleson.

1.18 Plan Year means the twelve (12) month period commencing January 1 and ending December 31.

1.19 Premium Expenses means the Participant's cost for benefits elected by the Participant, that are made available under this Plan as may be permitted under Code Section 125 and as described in section 4.01 of the Plan, including Appendix I. The maximum amount of Premium Expenses permitted during the Plan Year shall be determined periodically by the Employer and shall be based upon costs of the particular benefit and the Employer's allocation of those costs among the Employer and the Employee. The Employer may in its discretion allocate all or a portion of the cost to the Employee.

1.20 Salary Reduction means the amount by which a Participant's Compensation shall be reduced on a pre-tax basis to cover the Premium Expenses attributable to the benefit(s) elected pursuant to Article IV.

1.21 Similar Coverage means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide coverage for major medical are considered to be Similar Coverage. A health flexible spending account is not Similar Coverage for an accident or health plan that is not a flexible spending account. Coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as Similar Coverage.

1.22 Spouse means the legally married husband or wife of a Participant. The terms "husband" and "wife" shall be interpreted in accordance with Code Section 7701(a)(17) and Revenue Ruling 2013-17, 2013-38 I.R.B. 201, and shall be subject to such retroactive application as may be determined by the Internal Revenue Service through subsequent guidance.

ARTICLE II

PARTICIPATION

2.01 Eligibility

Each Employee who as of the Effective Date of this Plan receives benefits pursuant to a program described in Appendix I and who has Premium Expenses for that benefit, shall be eligible to participate in this Plan as of the Effective Date. Any new Employee is eligible to participate in this Plan as of the date coinciding with his eligibility for a benefit program described in Appendix I.

2.02 Enrollment

Each Employee who is eligible to participate in the Plan may, during the applicable Election Period, complete an Enrollment Form approved by the Employer. After electing to receive a benefit and agreeing to pay for the Premium Expense by Salary Reduction with pre-tax dollars, the Employee shall become a Participant in this Plan. The election made on the Enrollment Form shall be irrevocable until the end of the applicable Coverage Period unless the Participant is entitled to change his election pursuant to Article IV of this Plan. If a current Participant fails to provide a completed Enrollment Form to the Employer during the Election Period for an upcoming Plan Year, then section 4.02 shall control. However, such Participant shall be deemed to continue his prior Plan Year election for the upcoming Plan Year for any medical or health insurance Premium Expenses under a group health plan maintained by the Company.

2.03 Termination of Participation

Participation in this Plan of a Participant shall terminate on (a) his termination of employment for any reason, (b) the date on which he is no longer eligible for benefits hereunder, or (c) the termination of this Plan.

2.04 Rehires

If a Participant's coverage under this Plan is terminated because of the Participant's termination of employment, and the Participant is rehired during the same Coverage Period and within 30 days of the termination of employment, he or she may be permitted to resume participation in this Plan, provided that any Enrollment Form in effect prior to termination of employment is reinstated, and provided that the individual may again begin participation in the applicable benefit program. Notwithstanding the preceding sentence, if an event has occurred after termination and prior to rehire that would otherwise permit a change in election, the rehired Employee may be permitted to change the prior election accordingly. If an individual is rehired more than 30 days following his immediately preceding termination of employment, such Employee shall be treated as a new Employee for purposes of his or her elections under this Plan.

Nothing in this section 2.04 or in any other section of the Plan shall take precedence over the terms and conditions of the documentation for the benefits offered under this Plan, and such other documentation shall control as to eligibility for that benefit at any point in time and as to all other matters relating to that benefit to the extent there is any inconsistency between the Plan and the underlying documentation for any benefit offered hereunder.

ARTICLE III

CONTRIBUTIONS

3.01 Salary Reduction

If an eligible Employee elects the benefits described in section 4.01, pursuant to the applicable election procedure in Article IV, his Compensation shall be reduced in an amount equal to his Premium Expenses. Premium Expenses (which are Salary Reduction contributions) shall be calculated after taking into account any Employer Contribution Credit allocable to the benefit elected. Premium Expenses shall be deducted ratably during the Plan Year from the Participant's Compensation.

3.02 Employer Credit Contributions

The Employer may make a nonelective Employer Credit Contribution toward benefits under the Plan. The amount of the Employer Credit Contribution, if any, will be disclosed in Participant enrollment materials and will be limited as designated in the enrollment materials. Any unused Employer Credit Contribution will not be disbursed to a Participant in cash and shall be returned to the Employer, unless otherwise provided in the enrollment materials.

Notwithstanding the foregoing, the Employer may make periodical Employer Credit Contributions related to the completion or attainment of certain wellness goals or initiatives.

3.03 Application of Contributions

As soon as reasonably practical after each payroll period, the Employer shall apply the aggregate Salary Reduction to provide the benefit(s) elected by the affected Participants. Employer Credit Contributions shall be applied as directed by the Employer.

ARTICLE IV

ELECTION OF BENEFITS

4.01 Premium Expenses

Each eligible Employee shall have the right to elect to pay Premium Expenses under the Plan for benefits identified in Appendix I, on a Salary Reduction pre-tax basis. Such election shall be evidenced on forms provided by the Employer.

It is specifically provided that the only rights being granted to Participants under this Plan are the rights to pay Premium Expenses through Salary Reduction and rights under Section 125 of the Code with respect to the Participant's ability to choose among two or more benefits consisting of cash and qualified benefits. The Employer in no way guarantees, pursuant to this Plan, a Participant's eligibility for any benefit provided under any other employee benefit plan.

4.02 Annual Elections

During the Election Period, each eligible Employee shall be given the opportunity to elect, on an Enrollment Form provided by the Employer, benefits as set forth in Appendix I. Any such election shall be effective for any Premium Expenses incurred during the Coverage Period beginning on the date following the end of the Election Period. Similarly, any such election shall be effective for any Employer Credit Contribution made during the Coverage Period. In the event an eligible Employee or Participant shall not complete an Enrollment Form during the annual Election Period with respect to a reimbursement account that may be provided as a benefit hereunder, such failure to complete shall be deemed to be an election to not participate and to discontinue participation in such reimbursement account. In other words, participation in any reimbursement account requires an affirmative election to participate or to continue participation. However, as to any benefit option that is not a reimbursement account, the failure to complete an Enrollment Form during the annual Election Period shall be deemed to be consent to continue in effect the prior year's election, if any.

4.03 Elections by New Employees

A new Employee's Election Period shall be the period from his acceptance of an offer of employment through the date he becomes eligible to receive coverage for a benefit available under this Plan, or such other date as determined by the Committee. If the new Employee does not complete an Enrollment Form and deliver it to the Employer before such date, he may not make an election until the next subsequent Election Period. Any election pursuant to this section 4.03 shall not be effective until the first day of the month following the receipt of the Enrollment Form by the Employer (or such other date established by the Committee), and shall be limited to the Premium Expenses incurred in the portion of the Coverage Period for which the election is made.

4.04 Irrevocability of Elections

In general, an Employee's election of benefits under the Plan will be irrevocable for the duration of the Coverage Period. However, the Participant may be permitted to make an election change under this Plan subject to the provisions of the "Changes of Benefit Elections" section described below.

4.05 Changes of Benefit Elections

It is intended that this Plan shall allow, to the fullest extent provided by IRS regulations and authority, changes in benefit elections. An Employee who is permitted to make an election change under this section of the Plan must do so no later than 30 days (or 31 days if authorized by the underlying benefit program) of the event as described below in this Section 4.05. An Employee may revoke an election of benefits during a Coverage Period and/or make a new election only as provided in this section of the Plan. Further, even though an election change may be allowed under this section of the Plan, any such change desired shall not be allowed if allowing the desired change would be contrary to the terms of the document(s) governing the benefit to which the change of election applies. All election changes or new elections allowed shall be effective no sooner than the first day of the payroll period coinciding with or next following the date on which the Employee files a new Enrollment Form with the Plan administrator or makes a change thereto with the Plan administrator, except that elections to add medical coverage for a newborn or newly adopted Dependent child pursuant to the special enrollment rights described in (a) below may be retroactive in accordance with the special enrollment. Elections made pursuant to this section of the Plan shall be effective for the remainder of the Coverage Period in which the election is made, unless a subsequent event allows a further election change.

The Plan Administrator, in its sole discretion, has the discretionary authority to make all determinations required in order to determine whether the appropriate requirements have been met so that an Employee may change a benefit election, including the determination of any factual or legal question, including regulatory and other authority, and the interpretation of any provision of the Plan and application of the Plan.

(a) Special Enrollment Rights. An Employee may revoke an election for coverage under a group health plan during a Coverage Period and make a new election that corresponds with any special enrollment rights provided under the group health plan in accordance with the Health Insurance Portability and Accountability Act ("HIPAA") under Code Section 9801(f). Notwithstanding the preceding sentence and consistent with the provisions of Code Section 9801(f)(3), an Employee may make a new election under the Plan upon the occurrence of either of the following two events:

(1) Termination of Medicaid or CHIP Coverage. The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the

Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the Employee requests coverage under the Employer's group health plan not later than 60 days after the date of termination of such coverage; or

(2) Eligibility for Employment Assistance Under Medicaid or CHIP. The Employee or Dependent becomes eligible for assistance, with respect to coverage under the Employer's group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Employee requests coverage under the Employer's group health plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

(b) Changes in Status. An Employee may revoke an election during a Coverage Period and make a new election for the remaining portion of the Coverage Period (referred to as an election change) if, under the facts and circumstances, a Change in Status has occurred and the election change satisfies the consistency rules described below.

(1) Consistency Rule in General. An election change satisfies the consistency rule requirements only if the election change is on account of and corresponds with the Change in Status that affects eligibility for coverage under the benefit. For accident or health coverage and group-term life insurance, a Change in Status that affects eligibility includes a Change in Status that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage. An election change also satisfies the consistency rule requirements if the election change is on account of and corresponds with a Change in Status that affects expenses eligible for reimbursement under a dependent care reimbursement plan under Code Section 129 or an adoption assistance program under Code Section 137. In certain circumstances, additional requirements must be met in order to satisfy the consistency rule, as further explained below in subparagraph (2).

(2) In addition, if a Change in Status occurs as described below, then additional requirements must be met in order to satisfy the consistency rule requirements as follows:

(A) Divorce, Death, Cessation of Dependent Status. If the Change in Status is the Employee's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the Dependent Eligibility Requirements (as defined above in Article I), then an Employee's election to cancel any benefit that is accident or health coverage for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the Dependent Eligibility Requirements, respectively, fails to correspond with

that Change in Status. As an example, if a Dependent dies or ceases to satisfy the Dependent Eligibility Requirements, an election to cancel any accident or health coverage for any other Dependent, for the Employee, or for the Spouse, fails to correspond with that Change in Status and thus would not satisfy the consistency rule requirements.

(B) Becoming Covered Under Another Employer's Plan. If as a result of a Change in Status that involves either legal marital status or employment status, an Employee, Spouse, or Dependent gains eligibility for coverage under a cafeteria plan or benefit program that is sponsored by the employer of the Employee's Spouse or the Employee's Dependent, then an Employee's election under this Plan to cease or decrease coverage for that individual under this Plan corresponds with that Change in Status only if coverage for that individual becomes applicable or is increased under the cafeteria plan or such other benefit plan sponsored by the employer of the Employee's Spouse or the Employee's Dependent.

(C) Special Rule if Life/Disability Coverage is Offered. With respect to group-term life insurance or disability coverage that may be available under the Plan, an election to increase coverage (or an election to decrease coverage) in response to a Change in Status is deemed to correspond with that Change in Status as required by the consistency rule.

(D) Exception for COBRA. If the Employee, Spouse, or Dependent becomes eligible for COBRA continuation or similar state-law continuation coverage under any benefit which is subject to said continuation, the Employee may elect to increase payments under the Plan in order to pay for the continuation coverage.

(c) Judgment, Decree, or Order. If a judgment, decree, or order (collectively referred to as an "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined by ERISA Section 609), requires accident or health plan coverage for an Employee's child or for a foster child who is a Dependent of the Employee, and if such coverage is available and is provided for under the documents governing the benefit, then pursuant to such an order, the Plan may change the Employee's election to provide coverage for the child if the order requires coverage for the child under the Employee's plan; or the Plan may permit the Employee to change the Employee's election in order to cancel coverage for the child if the order requires the Spouse, former spouse, or other individual to provide coverage for the child and that coverage is, in fact, provided.

(d) Entitlement to Medicare or Medicaid. If an Employee, Spouse, or Dependent who is enrolled in an accident or health plan of the Employer becomes entitled to coverage by becoming enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act

(Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for the program for distribution of pediatric vaccines, the Employee may make a prospective election change to cancel or reduce coverage for that Employee, Spouse, or Dependent under the accident or health plan. In addition, if an Employee, Spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Employee may make a prospective election to commence or increase coverage for that Employee, Spouse, or Dependent under the accident or health plan.

(e) Cost Changes. THIS SECTION IS NOT APPLICABLE TO MEDICAL REIMBURSEMENT ACCOUNT PLANS.

(1) Insignificant Cost Changes. If the cost charged to an Employee for a benefit increases or decreases during a Coverage Period by an insignificant amount and Employees are required to make a change in their payment, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Employees' Salary Reduction accordingly to reflect the new cost.

(2) Significant Cost Changes. If the cost charged to an Employee for a benefit option significantly increases or significantly decreases during a Coverage Period, affected Employees may make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost. In the case of an increase in cost, the Employee may revoke an election for that coverage and, in lieu thereof, either receive on a prospective basis coverage under another option providing Similar Coverage; or the Employee may drop coverage if no other option providing Similar Coverage is available. Example: If the cost of an indemnity option under an accident or health plan significantly increases during a Coverage Period, Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another option, including an HMO option, or drop coverage under the accident or health plan if no other option is offered.

(3) Application of Cost Changes. For purposes of this section, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions (i.e., Salary Reduction) under the Plan, whether that increase or decrease results from an action taken by the Employee (such as switching between full-time and part-time status) or from an action taken by the Employer (such as reducing the amount of employer contributions for a class of Employees).

(4) Special Rules for Dependent Care. This section of the Plan related to cost changes applies in the case of a dependent care reimbursement plan under Code

Section 129 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 Sections 152(d)(2)(A) through (G), incorporating the rules of Code Sections 152(f)(1) and (4), and includes, for example, a Spouse, a son or daughter or other descendant, a stepson or stepdaughter, a brother or sister, a stepbrother or stepsister, a father or mother or other ancestor, a stepfather or stepmother, a nephew or niece, an uncle or aunt, a son-in-law, a daughter-in-law, a father-in-law, a mother-in-law, a brother-in-law, or a sister-in-law. This special rule, as set forth in this section, shall be construed so that a cost change also occurs if the Participant increases the salary of a non-relative household employee who provides dependent care services for the Participant.

(f) Coverage Changes. THIS SECTION IS NOT APPLICABLE TO MEDICAL REIMBURSEMENT ACCOUNT PLANS.

(1) Significant Curtailment Without Loss of Coverage. If an Employee (or an Employee's Spouse or Dependent) has a significant curtailment of coverage under a Benefit during a Coverage Period that is not a loss of coverage as described below in paragraph (f)(3) (for example, 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), then any Employee who has been participating in the Plan and receiving that coverage may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another option providing Similar Coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment. Example for Dependent Care: If due to a child starting school, the hours required for child care services are reduced, the change in hours will be treated as a coverage change, and a Participant may decrease his or her election under a Section 129 dependent care reimbursement plan accordingly.

(2) Significant Curtailment With Loss of Coverage. If an Employee (or an Employee's Spouse or Dependent) has a significant curtailment that is a loss of coverage as described below in paragraph (f)(3), then the Employee may revoke his or her election under the Plan and, in lieu thereof, may elect either to receive on a prospective basis coverage under another option providing Similar Coverage or to drop coverage if no Similar Coverage is available.

(3) Loss of Coverage. A loss of coverage means a complete loss of coverage under the benefit option (including the elimination of a benefit option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Plan administrator, in its discretion, may treat the following as a loss of coverage: (a) a substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a

member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or in an HMO); (b) a reduction in the benefits for a specific type of medical condition or treatment with respect to which an Employee (or an Employee's Spouse or Dependent) is currently in the course of treatment; or (c) any other similar fundamental loss of coverage.

(4) Addition or Improvement of a Benefit Option. If a plan adds a new benefit option, or if coverage under an existing benefit option is significantly improved during a Coverage Period, then eligible Employees (whether or not they have previously made an election under the Plan or have previously elected the benefit option) may revoke their election under the Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved benefit option. Example for Dependent Care: If a Participant finds a new child care provider, whether the new care provider is a household employee, a family member, or an independent person or entity, the situation is similar to a new benefit option becoming available under the Plan and may be treated as such. As a result, a Participant may change his or her election under a Code Section 129 dependent care reimbursement plan.

(5) Change in Coverage Under Another Employer Plan. An Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same Employer or of another employer) if (a) the other cafeteria plan or benefit option permits Participants to make an election change that would be permitted by IRS regulations under Code Section 125, as generally described in this section of the Plan; or (b) this Plan permits Participants to make an election for a Coverage Period that is different from the Coverage Period under the other cafeteria plan or benefit option. Example: If a Participant's Spouse is covered by a health plan sponsored by the Spouse's employer, and that plan has a plan year that differs from the Plan Year under this Plan, then this Plan will allow the Participant to add the Spouse if the Participant certifies that the Spouse will elect no coverage under the plan of the Spouse's employer during annual enrollment for the other plan and there is no reason to believe that the certification is incorrect.

(6) Loss of Coverage Under Other Group Health Coverage. An Employee may make an election on a prospective basis to add coverage under the Plan for the Employee, the Employee's Spouse, or the Employee's Dependent if such Employee, Spouse, or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including any one of the following: (a) A State's Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; (b) A medical care program of an Indian tribal government as defined in Code Section 7701(a)(40), the Indian Health Service, or a tribal organization; (c) A State health benefits risk pool; or (d) A Foreign government group health plan.

4.06 Participation During Leaves of Absence

The Family and Medical Leave Act ("FMLA") generally requires a covered Employer to offer coverage under any group health plan for the duration of a leave that is required to be extended by the FMLA, whether the leave is paid or unpaid. The group health plan coverage is to be offered under the same conditions as coverage would have been provided if the Employee had been continuously working during the entire leave period. The Employee has the right to keep this coverage by continuing to pay his or her cost of the premium. The requirements for Employees on paid FMLA leave are generally addressed by the FMLA and its regulations, which allow premium payments to be continued on the same basis as existed prior to the leave. The provisions below address benefit election choices under this Plan when the Employee is on an unpaid FMLA leave. Nothing herein shall be construed to alter the terms of any underlying benefit plan documentation and should not be construed to grant coverage under a benefit when the documentation for that benefit would not allow coverage to continue during a leave of absence.

(a) Health Benefits. Notwithstanding anything herein to the contrary and to the extent required by the FMLA, an eligible Employee may be permitted to terminate one or more health-related benefit elections (such as for group health coverage or for a medical reimbursement spending account) if the Employee takes an unpaid FMLA leave of absence. If such Employee terminates the receipt of a health benefit, or if the Employee continues the coverage yet coverage terminates because the Employee fails to pay the required premium, then there will be no coverage under the health benefit following such termination, and expenses incurred after termination are not eligible for payment. On timely return from an FMLA leave, the Employee shall be entitled to resume Plan participation under the same terms and conditions that existed prior to the leave. However, any terms and conditions that may have changed for active Employees also apply to the Employee returning from an FMLA leave.

Upon return from an FMLA leave during which coverage terminated, the Employer may require reinstatement into a health benefit that is a medical reimbursement spending account, provided that Employees on a non-FMLA leave are also required to be reinstated into the spending account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave. Example: If an Employee has elected $1,200 of annual coverage under a medical reimbursement account ($100 pre-tax funding monthly) and is on an FMLA leave during April, May, and June, during which coverage ceases, Employee on return from the leave in July may resume coverage at $1,200 by paying $150 per month from July through December. Alternatively, the

Employee may resume coverage at the reduced level of $900 annually by paying $100 per month from July through December.

In lieu of allowing an employee to elect to terminate the receipt of health-related benefits, the Employer may provide that health-related coverage automatically continues and allow the Employee to discontinue payment of his or her required premium during the period of the FMLA leave. Should this happen, the Employer has the right to recover the Employee's share of the premiums when the Employee returns to work, or as may otherwise be allowed by the FMLA.

If an Employee goes on an unpaid FMLA leave and chooses to continue one or more health-related benefits, the Employee may pay his or her share of the premium by one of the following methods. The optional methods provided below are to be offered in accordance with regulations under Code Section 125 relating to cafeteria plans and FMLA leaves, and in accordance with the Employer's practices and procedures:

(1) Pre-Pay. An Employee may pre-pay the premium for the expected duration of the leave either with after-tax dollars or with pre-tax dollars. Pre-tax dollars may not be used to pre-pay coverage during the subsequent Plan Year, and pre-payment may not be the sole method made available.

(2) Pay-As-You-Go. An Employee may make premium payments during the course of the leave by sending such payments as directed by the Employer, on a payroll period basis, or on any other basis as authorized. Contributions under this option are generally made on an after-tax basis. Coverage may cease if payments are not timely made, in accordance with the FMLA and its requirements. Alternatively, the Employer may choose to continue the health coverage of the Employee who fails to pay premiums. In such case, the Employer may recoup the premiums paid on the Employee's behalf, as authorized by regulations.

(3) Catch-Up. An Employee may make an advance agreement with the Employer that coverage will continue during the leave and that the Employee will not pay premiums until returning from the leave, after which time the Employee will catch-up those premium payments.

(4) Other. If any other option is made available to Employees on non-FMLA leave, then such option is also available to Employees on FMLA leave.

An Employee on FMLA leave has the right to revoke or change elections under the same terms and conditions as are available to active employees, as addressed in Articles I and IV of this Plan.

(b) Non-Health Benefits. If an Employee goes on an FMLA leave, then entitlement to non-health benefits shall be determined by the Employer's policies and

procedures for providing such benefits when an Employee is on a leave not covered by the FMLA, and also by the terms of the underlying benefit plan documentation. It is possible that an Employer may continue the Employee's non-health benefits while on FMLA leave in order to ensure that the Employee is eligible to be reinstated in the benefit upon return from leave as may be required by the FMLA. In such a case, the Employer is entitled to recoup the costs incurred for paying the Employee's share of the premium. Such costs may be recovered on any basis allowed by law.

If an Employee goes on a leave of absence that is not covered by the FMLA, such absence may constitute a Change in Status as addressed in Articles I and IV of this Plan. The ability of such Employee to continue any underlying benefit shall be determined by the terms and conditions of the underlying benefit plan documentation and by the Employer's policies and procedures. If the benefit can be continued, then this Plan accommodates the ability to pay for the benefit on a pre-tax basis where Compensation is available during the leave.

ARTICLE V

ADMINISTRATION

5.01 Plan Administration

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

(a) to make and enforce such rules and regulations as the Committee deems necessary or proper for the efficient administration of the Plan;

(b) to interpret the Plan; the Committee's interpretations thereof rendered in good faith shall be final and conclusive on all persons claiming benefits under the Plan;

(c) to decide all questions of fact and/or law concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan; and

(d) to appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan.

Further, the Committee is empowered to limit or modify the elections of highly compensated employees, highly compensated individuals, or key employees to the extent necessary to comply with any applicable non-discrimination requirements; however, any such limitation or modification shall be made in a uniform and consistent manner and shall not have the effect of circumventing any provision of the Code.

The Committee shall have the authority to allocate among its members or employees any of its duties and responsibilities under the Plan or may designate persons other than members or employees to carry out any of its duties and responsibilities. Any such designation shall carry with it the discretionary power of the Committee as set forth above, as to those duties and responsibilities that are so designated.

5.02 Insurance and Plans of Benefits

This Plan shall not affect the terms of any contract of insurance. An insurance company shall continue to have exclusive authority and discretion to interpret its contract and to manage and control any funds held by it to the extent permitted under the terms of any agreement or contract of insurance with the Employer. Further, this Plan shall not affect the terms of any program of benefits, whether insured or self-funded.

5.03 Examination of Records

The Employer shall make available to each Participant such records as pertain to the Participant, for examination at reasonable times during normal business hours.

5.04 Claims for Benefits

Any claim for benefits which arises under an insurance contract or a benefit program specified in section 4.01 shall be made in accordance with the terms of that contract or benefit program and in accordance with the claims procedures regulations issued by the U.S. Department of Labor.

ARTICLE VI

PARTICIPATION BY OTHER EMPLOYERS

6.01 Adoption of Plan

With the consent of the Company, any Employer which is treated as a single employer with the Company under subsections (b), (c), or (m) of Section 414 of the Code, or a successor company thereto, may become a participating Employer under the Plan by

(a) taking such action as shall be necessary to adopt the plan,

(b) filing with the Committee a copy of an executed adoption agreement in a form specified by the Company and attached to this Plan in Appendix II, and

(c) taking such other action as may be necessary or desirable to put the Plan into effect with respect to such Employer.

6.02 Withdrawal from Participation

Any Employer may withdraw from participating in the Plan at any time by filing with the Committee a copy of a resolution of its board of directors to that effect and giving notice of its intended withdrawal to the Company prior to the effective date of withdrawal. Notwithstanding the above, the Company may prohibit the withdrawal of an Employer if such withdrawal would cause the Plan to fail to satisfy any requirement under Section 125 of the Code.

6.03 Company Authorized to Act for Employers

Each Employer which shall become a participating Employer pursuant to section 6.01 shall be deemed to have appointed the Company to exercise on its behalf all the powers and authorities hereby conferred upon the Company by the terms of the Plan, including, but not by way of limitation, the power to amend and terminate the Plan. The authority of the Company to act as such shall continue until such Employer shall withdraw from the Plan. Notwithstanding the foregoing, the Company shall not have the authority to amend the Adoption Agreement executed by another Employer.

ARTICLE VII

AMENDMENT OR TERMINATION OF PLAN

7.01 Amendment or Termination

The Company reserves the right to amend, modify, revoke or terminate the Plan at any time, in whole or in part, without the consent of any Participant or Dependent. The authority to make any such changes to the Plan rests with the Committee or the appropriate authorized officers or other representatives of the Company.

ARTICLE VIII

MISCELLANEOUS

8.01 Plan Interpretation

This Plan document sets forth the provisions of this Plan. This Plan shall be read in its entirety and not severed except as provided in section 8.05.

8.02 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

8.03 Limitation on Participant Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

(a) to give any person any legal or equitable right against any Employer or the Committee, except as expressly provided herein or provided by law; or

(b) to create a contract of employment with any Participant, to obligate the Employer to continue the service of any participating Employee or to affect or modify his or her terms of employment in any way.

8.04 Governing Law

This Plan is governed by Section 125 of the Internal Revenue Code and the regulations issued thereunder, to the extent that such Code section addresses a provision provided in this Plan. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not addressed by Section 125 of the Internal Revenue Code or

not otherwise preempted by federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of TX.

8.05 Severability

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

8.06 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan or in any way shall affect the Plan or the construction of any provision thereof.

8.07 Non-Gender Clause

Whenever used in this Plan, the masculine gender shall include the feminine and the plural form shall include the singular.

ARTICLE IX

ADOPTION OF THE PLAN

IN WITNESS WHEREOF, the authorized representative of the Company whose name appears below has executed the Plan document **this** [1st **day of** September, **to be effective** January 1, 2020].

KAREN E. GOODMAN
Notary Public, State of Texas
Comm. Expires 08-24-2021
Notary ID 125391700

ATTEST: (SEAL)

By: Karen E. Goodman

City of Burleson

By: _____

Title: City Manager

APPENDIX I

The following benefits are offered pursuant to Plan section 4.01, as authorized by Section 125 of the Code.

Medical Reimbursement Account Benefits
Dependent Care Reimbursement Account Benefits

APPENDIX II

ADOPTION AGREEMENT FOR THE
City of Burleson
SECTION 125 CAFETERIA PLAN

_____ hereby adopts the City of Burleson Section 125 Cafeteria Plan (the Plan) in accordance with section 6.01 of the Plan as an adopting Employer this [1st **day of** September, **to be effective the** 1st **day of** January 2020].

ATTEST: (SEAL)

KAREN E. GOODMAN
Notary Public, State of Texas
Comm. Expires 08-24-2021
Notary ID 125391700

By: Karen E. Goodman

City of Burleson

By: _____

Title: City Manager

City of Burleson
Section 125 Cafeteria Plan
Summary Plan Description

Effective as Amended and Restated January 1, 2020

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INTRODUCTION

City of Burleson has implemented a Section 125 Cafeteria Plan to enable you to purchase certain benefits on a pre-tax basis.

The benefits may include insurance and other fringe benefits allowable under Section 125 of the Internal Revenue Code. The benefit programs are listed in Appendix A and are described in separate documentation that you should have received. Once you elect to purchase the benefits on a pre-tax basis, you cannot as a general rule change your election until the next annual enrollment period. However, if you have a *Change in Status Event* as described below, you may be able to make a change in your election. In most cases, you will have 30 days to make a change. However, if the particular benefit that you want to change provides that you have 31 days, this Plan will also provide 31 days. A change due to a *Change in Status Event* must be on account of and must correspond with that *Event*. Please keep in mind that nothing in this Summary Plan Description overrides the terms and conditions of the plan documentation for the benefits that are available through this Section 125 Cafeteria Plan for pre-tax purchase, so you must always follow the terms of those plans.

If your employer offers Flexible Spending Accounts, this Summary Plan Description does not address those Accounts. Rather, they are addressed in a separate Summary Plan Description.

If there is any difference between information described in this Summary Plan Description and the Plan's formal documentation, the formal documentation will control. The formal documentation is subject to rules, regulations, and interpretations under Section 125 of the Internal Revenue Code, which will ultimately control the interpretation of any matter under the Section 125 Cafeteria Plan
.

ELIGIBILITY

Each Employee who normally performs services for the Employer of at least 30 hours per week may elect to participate in the Plan as of the beginning of the next following Coverage Period. Any Employee whose employment begins after the beginning of a Coverage Period may begin participation on the First day after the end of waiting period after completing 1 months of service with the Employer.

Participation

You become a Participant by completing the benefit election form or other enrollment process supplied by the Company wherein you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected.

Annual Enrollment Period

An annual enrollment period will be scheduled by City of Burleson prior to the beginning of each plan year. At that time you will receive enrollment materials describing options available to you under the Plan. You will be given the opportunity to change your choices made for the previous 12-month period, for the coming 12 months. Failure to complete the form or other enrollment process supplied by the Company at the annual enrollment period shall be deemed as an election to continue the elections from the previous Plan Year. This deemed election will occur for all benefits except Flexible Spending Accounts, which require a new election each year. After an election is made, it may not be modified until the next annual enrollment period unless there is a Change in Status or other IRS authorized event that allows an election change.

Electing Less than the Maximum Allowed Benefit

Any portion of your Compensation that you do not choose to apply toward the purchase of the benefits described will be paid to you as regular, taxable Compensation.

Change in Status Events

Rules of the Internal Revenue Code require that generally, you may not change your benefit plan elections until the next annual enrollment period. However, you will be allowed to make a change if the change is a *Change in Status Event* and the *Consistency Rule* is satisfied. Valid *Change in Status Events* include the following:

- Change in Employee's Legal Marital Status (marriage, divorce, annulment, legal separation or death of spouse).

- Change in Number of Dependents (events that change an employee's number of dependents, such as birth, adoption, placement for adoption or death).

- Change in Employment Status of Employee, Spouse or Dependent (any of the following that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, change in worksite, or a change from an eligible to an ineligible employment status or classification).

- Dependent Satisfies (or Ceases to Satisfy) Dependent Eligibility Requirements (events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as due to age, student status, or similar circumstances). Please note that effective March 30, 2010, dependent children include your adult children until the child attains age 26, as required by the new health reform law.

- Change in Residence (a change in the place of residence of the employee, spouse, or dependent).

Other *Change in Status Events* may be allowed if they are acceptable under interpretations of the Internal Revenue Code. If you have questions, please ask your Employer's benefits representative.

If you experience a *Change in Status Event* and desire to make a change, you must make the change no later than 30 days following the *Event*. However, if the benefit you wish to change allows 31 days to make changes, this Plan will also allow 31 days.

Consistency Rule

A change must be "on account of and correspond with" a Change in Status Event. To meet this requirement, the change that you wish to make must be on account of and correspond with a *Change in Status Event* that affects eligibility for coverage under an employer's plan. The determination of whether a requested change is "on account of and consistent with" a *Change in Status Event* will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service. If you have questions, please ask your Employer's benefits representative.

Other Events That May Allow Election Changes

- HIPAA Special Enrollment Rights. If you, your Spouse and/or a Dependent are entitled to special enrollment rights under the provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996, as amended) for a group health plan, you may change your election to correspond with the special enrollment right. Your special enrollment right may also include the termination of Medicaid or CHIP coverage or eligibility for employment assistance under Medicaid or CHIP coverage. CHIP coverage refers to a state child health plan under Title XXI of the Social Security Act. Please refer to the group health plan description for an explanation of special enrollment rights.

- Judgment, Decree, or Order. If a judgment, decree, or order (collectively called "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under the Employee Retirement Income Security Act) requires an employee to cover a child or children under a group health plan, the employee may change his or her election to cover the child(ren). Likewise, if the order requires another individual to provide coverage for the child and coverage is, in fact, provided, then the employee may change his or her election to drop coverage for the child(ren).

- Medicare and Medicaid. If an employee, spouse, or dependent becomes entitled to Medicare or Medicaid (other than coverage only for pediatric vaccines), the employee may make a change in election to cancel or reduce any group health coverage available through this Plan for the individual. Likewise, if the employee, spouse, or dependent loses eligibility for coverage under Medicare or Medicaid (other than coverage only for pediatric vaccines), the employee may make a change in election to commence or increase any group health coverage available through this Plan for the individual.

- Cost Changes. If the cost of qualified benefits increases or decreases during the plan year, your election may be automatically adjusted, if the Company in its discretion chooses to change your cost. If the cost significantly increases, you will be permitted to make an election change to increase your payment or to revoke your election and, in lieu thereof, to receive on a prospective basis coverage under another benefit option similar coverage. You may also be permitted to revoke your election and drop coverage if no other option providing similar coverage is available. See your benefits representative for additional information.

- Significant Coverage Change/Curtailment. If the coverage under a benefit is significantly changed or curtailed, you may revoke your election and make a new election on a prospective basis for coverage under another option that provides similar coverage. If the coverage is lost altogether, you may drop your election if no similar coverage is available.

- Addition or Improvement of Benefit Option. If during the plan year the Plan adds or significantly improves a benefit option, you may elect the newly added or improved option.

- Change in Coverage of Spouse or Dependent Under Other Employer's Plan. If there is a change in your, your spouse's, or your dependent's coverage of a qualified benefit under another employer's plan, you may be allowed to change your election under the Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

The Plan Administrator, in its discretion, has the authority to interpret all rules that are applicable to the Section 125 Cafeteria Plan. Further, the Plan 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.

TAX ADVANTAGES

The cash compensation (wages) you receive from City of Burleson is taxable. However, when you allocate a portion of your compensation on a pre-tax basis to be used for payment of your benefits, your taxable income is reduced by the amount you have allocated to benefits. This allocation results in a reduction of federal and, in most cases, state income taxes.

Social Security/Other Benefits May Be Affected

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in your Social Security benefits which may be based on taxable compensation. Although this reduction usually is quite small, it could occur if your compensation falls below the annual Social Security taxable wage base as revised each year. The resulting decrease in your taxable compensation could impact other benefits which may be available through your employer.

CHANGES TO EMPLOYEE'S STATUS

If your employment status changes, participation in the Plan is affected as follows:

Leave of Absence Under the FMLA

If your employer continues any benefit you have elected under the Plan during an FMLA leave, your participation may continue for as long as you are on paid leave or, if the leave is unpaid, you may pay premiums in a manner approved by the employer. In no event, however, will this provision override the terms of any insurance or other program under which the benefit is provided, nor will it override the substance of any employer policy regarding leaves of absence. You should discuss these issues with the benefits representative. You may be entitled to cease participation while you are on FMLA leave. If you cease participation as evidenced by non-payment of premiums, you will not be considered a participant in the Plan, and you will not receive benefits during the time you were not a participant. If you timely return from FMLA leave, you can elect to be reinstated in the Plan on the same terms as existed prior to your FMLA leave (unless those terms were changed in the meantime for other plan participants).

Non-FMLA Leave of Absence

If the employer's policies provide for a paid leave of absence that is not covered by the FMLA, your participation may continue as provided by those policies, as long as you continue to receive compensation. If your leave of absence is unpaid, you should review your options with the employer's benefits representative. In no event will this provision override the terms of any insurance or other program under which the benefit is provided.

Death

In the event of your death, your participation ceases as of the date of your death.

Change to Ineligible Employment Status

Your participation ceases as of the date of the change in your employment status.

Termination of Employment

Your participation ceases as of the date of your termination.

If the events described above cause a loss of coverage under a group health plan, you may be eligible for Continuation Coverage for group health plans. Continuation coverage, if any, is governed by the terms of the health plan and by laws that apply to group health plans. Continuation coverage is not addressed in this Summary Plan Description.

MORE IMPORTANT FACTS

The Plan is provided through and administered by City of Burleson.

Plan Name

City of Burleson Section 125 Cafeteria Plan. This Plan authorizes the payment of certain benefits with pre-tax dollars.

Plan Documents

City of Burleson' Plan is fully described in the Plans' legal document. This booklet describes the major provisions of the Section 125 Cafeteria Plan in easy to understand terms. It is shorter and far less technical than the Plans' legal documents. If there is any conflict or inconsistency between this booklet and the Plans' legal documents, or if this booklet does not cover or only partially covers any provision in the legal documents, the Plans' legal documents govern. If you have any questions about the Plans or if you would like to examine the Plans' legal documents, contact City of Burleson. It is intended that the Plans will be administered in accordance with all relevant statutory and governmental authority. To the extent that any Plan provision is contrary to any statutory and governmental authority, such authority will govern operation of the Plans.

Effective Date

The effective date of the plan is January 1, 2016.

Plan Sponsor/Plan Administrator

City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

The Plan Administrator has the discretionary authority to administer the Plan in all of its details, including determining eligibility for benefits and construing all terms of the plan. The Plan Administrator has the discretion to determine all questions of fact and/or law that may arise in connection with the administration of the Plan. The Plan Administrator may assign its duties to others.

Legal Service

The agent for service of legal process for the City of Burleson Section 125 Cafeteria Plan is:

Corporate Secretary
City of Burleson
141 W Renfro
Burleson, TX 76028

Plan Number

501

Plan Sponsor's Identification Number

75-6000475

Plan Year

The Plan year begins on January 1 and ends on December 31.

Sources of Contributions

Employees contribute to the plan through pre-tax dollars that are elected by the employee and authorized by the Section 125 Cafeteria Plan. Employees select the amount of their contributions, up to authorized limits. A minimum contribution may be required. There is no trust fund applicable to the Plan. All payments hereunder involve the Employer's general assets.

Future of the Plan

City of Burleson intends to continue the Plan indefinitely. However, it reserves the right to change or to terminate the Plan, or to eliminate any benefit under the Plan, at any time without the consent of any participant or dependent. City of Burleson or any authorized officer or representative of City of Burleson can make changes to or terminate the Plan. You will be notified if any changes are made.

CLAIMS DECISIONS AND APPEALING A DENIED CLAIM

The following information is provided for general information about claims and review procedures for benefit plans that are covered by the Employee Retirement Income Security Act ("ERISA"). It is based upon regulations issued by the U.S. Department of Labor, and is not intended to override the claims and review procedures that may be contained in the documentation for any underlying benefit program that may be available for purchase through this Plan with pre-tax dollars. You should always consult the documentation that you have been provided for the benefit that you have elected to purchase under this Plan.

Different timelines for deciding claims, submitting appeals, and deciding appeals apply based upon whether the claim relates to a disability benefit, to a medical benefit, or another type of benefit. The information provided below illustrates the claims and review procedure only for a medical benefit that is a post-service claim. Again, this is only provided for general information, and you should consult the documentation for your specific benefit plan.

Post-Service Medical Claims Decisions. Within 30 days after receipt of a claim, the Plan will make reimbursement for expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied. The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process for Post-Service Medical Claims. In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial within 180 days after receipt of written notice of the denial. Your written request should be sent to the Claims Administrator, which will forward your request for review to the Plan Administrator. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil action in court as described under "Statement of ERISA Rights" below. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing for a review of the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to pursue your rights under ERISA, including your right to file a lawsuit, as described in the "Statement of ERISA Rights" below.

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding.

STATEMENT OF ERISA RIGHTS

The information provided below applies to benefit programs that are covered by the Employee Retirement Income Security Act ("ERISA"). This information is not intended to replace a similar statement provided in the underlying benefit program that is offered by this Plan, but is provided for your information. This Section 125 Cafeteria Plan is not itself covered by ERISA. However, benefits may be offered under the Plan that are subject to ERISA. If a plan is subject to ERISA, you are entitled to certain rights and protections under that law. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at your Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Upon written request to the plan administrator, obtain copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

COBRA Continuation Coverage

If your Employer and the applicable benefit plan are subject to COBRA, you may have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the applicable summary plan description and the documents governing any health plan for the rules governing these rights.

If your Employer and the applicable benefit plan are subject to HIPPA, you may have the right to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting conditions exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Review the applicable summary plan description and the documents governing any health plan for the rules governing these rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if one is required) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case the court may require the plan administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the Plan's money (if the Plan is considered to have money), or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance With Your Questions

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

Newborns' and Mothers' Health Protection Act of 1996

Under ERISA, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Appendix A:

List benefits available under the Plan:

Group Health, Dental, Vision, HSA

MASTER DOCUMENT

City of Burleson

FLEXIBLE SPENDING ACCOUNT PLAN

Medical Reimbursement Account: Carryover

Dependent Care Reimbursement Account: Standard

Effective as Amended and Restated January 1, 2020

City of Burleson

FLEXIBLE SPENDING ACCOUNT PLAN

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INTRODUCTION

Effective Jan 1, 2016, City of Burleson (the "Company"), adopted the City of Burleson Flexible Spending Account Plan (hereinafter referred to as the "Plan"). Effective as of January 1, 2020, the public.company hereby adopts the ammended and restated Plan.

The purpose of this Plan is to offer the eligible Employees of the Employer the ability to receive certain reimbursement of medical expenses not reimbursed through other sources and to receive reimbursement of certain dependent care expenses. This Plan shall operate in conjunction with the Section 125 Cafeteria Plan so that such reimbursement is provided in part or in whole through pre-tax reduction of the Employee's compensation. The Plan is intended to comply with the requirements of Section 105, 106, and 129 of the Internal Revenue Code of 1986, where applicable, as amended from time to time.

ARTICLE I

DEFINITIONS

The following terms when used herein shall have the following meanings, unless a different meaning is plainly required by the context. Capitalized terms are used throughout the Plan text for terms defined by this and other sections.

1.01 Change in Status means any of the events described under Code Section 125 and the regulations issued thereunder, as well as any subsequent changes to the Code or such regulations and interpretations thereof, that the Plan Administrator, in its sole discretion, recognizes on a uniform and consistent basis, and as set forth in the accompanying Section 125 Cafeteria Plan.

1.02 Code means the Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings pertaining to such section and shall also be deemed a reference to comparable provisions of future laws.

1.03 Committee means the individual or individuals appointed by the Company to carry out the administration of the Plan. In the event the Committee has not been appointed, or resigns from a prior appointment, the Company shall be deemed to be the Committee.

1.04 Company means City of Burleson and/or any successor thereto. The Company is the plan sponsor, the plan administrator for purposes of ERISA, and the named Fiduciary.

1.05 Compensation means the total cash remuneration received by the Participant by the Employer during a Coverage Period prior to any reductions pursuant to an Enrollment Form authorized hereunder and prior to any Salary Reduction pursuant to Code Section 401(k), 403(b), 408(k), 457(b), 132(f), or 125, as applicable.

1.06 Coverage Period means the Plan Year during which a Participant elects to receive benefits under the Plan, provided that, for any Employee who becomes a Participant after the start of a Plan Year, the initial Coverage Period shall mean the period commencing on the effective date of such Participant's participation and extending through the remainder of the Plan Year.

1.07 Dependent means a Participant's Spouse, a Participant's child(ren) who meet the definition of dependent at Internal Revenue Code ("IRC") Section 152, or any other person meeting the definition of dependent at IRC Section 152, who is eligible to receive benefits hereunder in accordance with the Enrollment Form for purposes of receiving reimbursements. Notwithstanding the above, effective as of January 1, 2005, and as allowed by IRC Section 105, as amended by the Working Families Tax Relief Act of 2004, for purposes of the Medical Reimbursement Account, Dependent is determined without regard to Section 152(b)(1) (generally having to do with the inability of a person claimed as a dependent, to claim others as the person's dependent; i.e., dependent cannot have dependents), Section 152(b)(2) (generally having to do with joint returns by spouses), and Section 152(d)(1)(B) (generally having to do with gross income limitations for a qualifying relative). Further, any child to whom IRC Section 152(e) applies (having to do with special rules for divorced parents) shall be treated as a Dependent of both parents for purposes of the Medical Reimbursement Account. For dependent care expenses, Dependents shall have the meaning as defined in Code Section 152, except that in the case of such a Dependent who is a qualifying relative, or in the case of a Spouse, such Dependent or Spouse must be physically or mentally incapable of caring for himself or herself, and such Dependent or Spouse must have the same principal place of abode as the taxpayer for more than one-half of the taxable year. In the case of a Participant who has been divorced, the Dependent child shall be defined as provided in Code Section 21(e)(5). Further, in the event that the IRC is amended, such as a technical correction to address a potentially unintended impact of the Working Families Tax Relief Act of 2004 on the definition of "dependent" for purposes of IRC Section 129 for Dependent Care Assistance Programs, including IRC Section 21, or for any other purpose, the definition of Dependent herein shall automatically change along with such IRC amendment, without additional action to this Plan, to conform with such IRC amendment. Effective March 30, 2010 and in addition to the foregoing, the term Dependent shall include a Participant's children who are adult children until the individual child attains 26 years of age, as required by Section 2714 of the Public Health Services Act.

Under the Medical Reimbursement Account, benefits will be provided in accordance with the applicable requirements of any qualified medical child support order, as defined in ERISA Section 609. Further, under the Medical Reimbursement Account, the term "child" may include, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age 18 as of the date of such adoption or placement for adoption, provided that other requirements of IRC Section 152 are satisfied with respect to the child. The term "placement for adoption" means the assumption and retention by such person of a legal obligation for total or partial support of such child in

anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

1.08 Dependent Care Account means the bookkeeping account established for each Participant to reflect the transactions of the Plan in providing Dependent Care Account benefits to Participants in accordance with Article VI and the Company election in Appendix I.

1.09 Effective Date of this amended and restated plan means January 1, 2020, or such later date as of which an adopting Employer adopts the Plan for its Employees.

1.10 Election Period means the period designated by the Company, and communicated to Employees in advance, preceding each Coverage Period, during which Participants may make elections to participate in the Plan pursuant to the terms of the Section 125 Cafeteria Plan. For any Employee who first becomes eligible to become a Participant during a Coverage Period, his or her Election Period shall begin following employment. Such Election Period shall be for a period of not less than two weeks.

1.11 Employee means any person employed by the Employer as a common-law employee of the Employer. The term shall specifically exclude self-employed individuals as described in Code Section 401(c) or Employees who are members of a collective bargaining unit for which benefits under this Plan have not been provided pursuant to a collective bargaining agreement with the Employer.

1.12 Employer means the Company and any other Employer that adopts this Plan pursuant to Section 8.01 and consented to by the Company from time to time, and included in Appendix II to this Plan.

1.13 Employer Credit Contribution means any amount which the Employer, in its sole discretion, may contribute on behalf of Participants toward benefits, as provided under Section 125 Cafeteria Plan. The amount of the Employer Credit Contribution, if any, will be disclosed in Participant enrollment materials. The Employer Credit Contribution will be limited as designated in the enrollment materials. Except as otherwise provided in the enrollment materials, no Employer Credit Contribution will be disbursed to a Participant in cash, and any unused contributions shall be returned to the Employer.

1.14 Enrollment Form means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego increases in such Compensation and to have an equivalent amount contributed by the Employer to the Plan on the Participant's behalf. The Enrollment Form shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the Enrollment Form (after taking this Plan into account) and subsequently does not become currently available to the Participant.

1.15 Fiduciary means the Company, Employer, Committee, any Insurance Company, and any other individual, Company, firm or other entity, to the extent that any of the above

exercises discretionary authority or control over Plan management, disposition of any plan assets, or administration of the Plan.

1.16 Flexible Spending Account means the bookkeeping account established for each Participant to reflect the transactions of the Plan in accordance with Section 3.03. The Flexible Spending Account may consist of either or both a Medical Reimbursement Account and a Dependent Care Account maintained pursuant to this Plan in accordance with Appendix I.

1.17 Flexible Spending Account Expenses means the Participant's cost for the benefit(s) described in Section 4.01, plus any Employer Credit Contribution that may made toward the benefit(s) pursuant to the terms of the Section 125 Cafeteria Plan.

1.18 Grace Period means, with respect to any Plan Year, two months and fifteen days after the end of such Plan Year, during which Dependent Care Expenses may be incurred pursuant to Section 6.03 of the Plan, and be attributed to benefits or contributions remaining unused in the Participant's Dependent Care Reimbursement Account at the end of the Plan Year that immediately precedes the Grace Period.

1.19 Health Care Plan means the group health care plan maintained by an Employer to provide health and welfare benefits to its employees.

1.19 Medical Expense means expenses for medical care (except for qualified long-term care services and eligible long-term care insurance premiums) as defined in Code Section 213(d).

Notwithstanding the foregoing, effective for expenses incurred on and after January 1, 2011 for a medicine or a drug, such expenses shall be treated as eligible for tax-free reimbursement under this Plan as a Medical Expense only if the individual obtains a prescription with the meaning of IRS Notice 2010-59, as amended or superseded from time to time, for such medicine or drug (determined without regard to whether such drug is available without a prescription) or is Insulin. Thus, Medical Expenses incurred on or after January 1, 2011 for medicines or drugs may be reimbursed by this Plan only if (1) the medicine or drug requires a prescription, (2) is available without a prescription (an over-the-counter medicine or drug) and the individual obtains a prescription, or (3) is Insulin.

1.20 Medical Reimbursement Account means the bookkeeping account established for each Participant to reflect the transactions of the Plan in providing Medical Reimbursement Account benefits to Participants in accordance with Article V and the Company election in Appendix I.

1.21 Participant means, in accordance with Article II, any Employee who is eligible to participate in this Plan, elects and receives Medical Reimbursement Account or Dependent Care Account benefits, and whose participation in the Plan is not terminated.

1.22 Plan means the City of Burleson Flexible Spending Account Plan, including any successor plan.

1.23 Plan Administrator means City of Burleson.

1.24 Plan Year means the twelve (12) month period commencing January 1 and ending December 31

1.25 Salary Reduction means the amount by which a Participant's Compensation shall be reduced on a pre-tax basis pursuant to the terms of the Section 125 Cafeteria Plan to cover all or a portion of the Flexible Spending Account Expenses attributable to the benefit(s) elected pursuant to Article IV.

1.26 Spouse means the legally married husband or wife of a Participant. The terms "husband" and "wife" shall be interpreted in accordance with Code Section 7701(a)(17) and Revenue Ruling 2013-17, 2013-38 I.R.B. 201, and shall be subject to such retroactive application as may be determined by the Internal Revenue Service through subsequent guidance.

ARTICLE II

PARTICIPATION

2.01 Eligibility

Each Employee who normally performs services for the Employer of at least 30 hours per week may elect to participate in the Plan as of the beginning of the next following Coverage Period. Any Employee whose employment begins after the beginning of a Coverage Period may begin participation on the First day after the end of waiting period after completing 1 months of service with the Employer.

2.02 Enrollment

Each eligible Employee shall, during the applicable Election Period, complete an Enrollment Form approved by the Employer. An election made on the Enrollment Form to participate in the Plan shall be irrevocable until the end of the applicable Coverage Period unless the eligible Employee is entitled to change his election pursuant to Section 4.04 hereof. The Enrollment Form is hereby made a part of and incorporated by reference into this Plan.

A Participant shall be required to execute a new Enrollment Form during the Election Period preceding each Coverage Period during which he wishes to participate in this Plan. A Participant shall have the right to revoke any prior Enrollment Form during an Election Period effective the first day of the next Coverage Period.

In the event an eligible Employee or a Participant shall not complete an Enrollment Form, such shall be deemed to be an election of cash as may be represented by the Participant's ongoing Compensation.

2.03 Termination of Participation

(a) Participation in this Plan shall terminate on (a) the date on which a Participant is no longer eligible for benefits hereunder, or (b) the termination of this Plan. When a Participant ceases to be a Participant under this Plan, the Participant's Salary Reductions will cease, as will the Participant's election to receive reimbursements under the Plan. The Participant will not be able to receive reimbursements for expenses incurred after participation terminates. However, the Participant (or the Participant's estate as applicable) may file a claim for reimbursement for any expenses incurred during the Coverage Period prior to termination in accordance with the appropriate procedures for submitting a claim.

(b) If the Company is subject to the requirements of COBRA, and if termination of participation in the Plan is a COBRA qualifying event, then COBRA continuation coverage will be offered from the Medical Reimbursement Account through the end of the Plan Year in which the qualifying event occurred. However, COBRA will be offered only to qualified beneficiaries who can become entitled to receive, during the remainder of the Plan Year following the qualifying event, a benefit that exceeds the maximum amount that the law permits as payment for COBRA continuation coverage for the remainder of the Plan Year. Specifically, such Participants will be eligible for COBRA continuation coverage only if they have a positive Medical Reimbursement Account balance at the time of a COBRA qualifying event, taking into account all claims submitted before the date of the qualifying event. The intent of this section is that COBRA will not be offered to participants who have "overspent" their Medical Reimbursement Account. If a Participant elects COBRA, coverage will be available on a self-pay basis for the same coverage that the Participant had under the Medical Reimbursement Account on the day before the qualifying event and only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the Medical Reimbursement Account will cease at the end of the Plan Year and cannot be continued for the next Plan Year. This section will be interpreted according to regulations that have been issued under COBRA.

ARTICLE III

CONTRIBUTIONS

3.01 Salary Reduction

If an eligible Employee elects one or more of the benefits described in Section 4.01, pursuant to the applicable election procedure in Article IV, his Compensation shall be reduced through Salary Reduction in an amount equal to his Flexible Spending Account election. However, the amount of the Salary Reduction shall not include any Employer Credit Contribution that may be provided for the elected benefit pursuant to the terms of the Section 125 Cafeteria Plan. The Salary Reduction amount shall be deducted ratably during the Plan Year from the Participant's Compensation.

3.02 Employer Credit Contributions

The Employer may make a nonelective Employer Credit Contribution toward benefits, as allowed by the Section 125 Cafeteria Plan. The amount of the Employer Credit Contribution, if any, will be disclosed in Participant enrollment materials and will be limited as designated in the enrollment materials. Any unused Employer Credit Contribution will not be disbursed to a Participant in cash and shall be returned to the Employer, unless otherwise provided in the enrollment materials.

3.03 Application of Contributions

An account shall be maintained for each Participant electing to participate in this Plan in an amount equal to aggregate Salary Reduction elected by the affected Participant plus any applicable Employer Credit Contribution. In the event that a Participant elects to participate in both the Medical Reimbursement Account and the Dependent Care Account, if permitted in accordance with Appendix I, a separate account will be maintained for each benefit.

ARTICLE IV

ELECTION OF BENEFITS

4.01 Benefits

Each eligible Employee may elect to enroll in a Flexible Spending Account as set forth in Appendix I. Such election(s) shall be evidenced on forms provided by the Employer.

The Employer in no way guarantees, pursuant to this Plan, a Participant's eligibility for any benefit provided under this Section.

4.02 Annual Elections

During the Election Period, each eligible Employee shall be given the opportunity to elect, on an Enrollment Form provided by the Employer, benefits as set forth in Section 4.01. Any such election shall be effective for expenses incurred during the Coverage Period beginning on the date following the end of the Election Period.

4.03 Elections by New Employees

An Employee whose employment begins after the beginning of a Coverage Period may not receive benefits under the Plan until after the period during which the Employee becomes a Participant in the Plan in accordance with Article II.

4.04 Change of Elections

Any Participant may change a previous election made pursuant to the Plan after the Coverage Period (to which such election relates) has commenced and make a new election with respect to the remainder of such Coverage Period if the change is provided for in the corresponding Section 125 Cafeteria Plan. An authorized change must be made in a timely manner as provided in the Section 125 Cafeteria Plan.

4.05 Failure to Elect

Any eligible Employee or Participant failing to complete an Enrollment Form pursuant to Section 4.02 by the end of an applicable Election Period shall not be allowed to participate in the Plan for the Coverage Period to which the Election Period applies.

ARTICLE V

MEDICAL REIMBURSEMENT ACCOUNTS

5.01 Medical Reimbursement Accounts

(a) Medical Reimbursement Account benefits, if any, shall be provided to the extent permitted in Appendix I.

(b) The Medical Reimbursement Account shall be used to reimburse eligible Participants for all Medical Expenses at convenient intervals, up to the maximum amount of such account elected on the Participant's Enrollment Form, which maximum amount shall include any available Employer Credit Contribution. Such expense reimbursement must be attributable to the Employee, paid for himself or herself, or for his or her Spouse, or his or her Dependents, in excess of any payments or other reimbursements under any health plan which may be sponsored by the Employer, any governmental agency on behalf of said eligible Participants and their Spouses and Dependents or carried personally by said eligible Participants and covering themselves and/or their Dependents.

In order to be reimbursed under this account, a Participant shall provide a reimbursement claim form, along with a copy of the invoice stating that the Medical Expense has been incurred and the amount of such expense. An expense is incurred when the Participant is provided with the care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care. Further, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage.

Benefits provided hereunder shall be used to pay claims directly to the Participant. The general classes of covered expenses under the account will be:

-- Nursing care,
-- Hospital bills,
-- Doctors' and dentists' bills,
-- Psychiatric care,
-- Drugs and prescriptions, and
-- Medical-related transportation.

Included in the foregoing, but not by way of limitation, will be all medical and dental expenses, including hospital expenses, both room and board and special hospital services; surgical expenses; diagnostic x-rays; prenatal and maternity expenses; infant care in hospital; services of physicians, surgeons and specialists, in or out of hospital; rental of iron lung or other equipment for therapeutic appliances; diagnostic laboratory procedures; drugs and medicine requiring prescriptions; oxygen; anesthesia; blood and plasma; x-ray and radium treatments;

local professional ambulance services; psychiatric treatment; dental care; surgery and appliances; eye glasses; hearing aids and examination thereof. However, expenses for qualified long-term care benefits shall not be considered covered expenses under the Plan.

Effective January 1, 2011 expenses incurred for a medicine or a drug shall be treated as eligible for tax-free reimbursement under this Plan as a Medical Expense only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is Insulin. Thus on or after January 1, 2011, Medical Expenses incurred for medicines or drugs may be reimbursed by this Plan only if (1) the medicine or drug requires a prescription, (2) is available without a prescription (an over-the-counter medicine or drug) and the individual obtains a prescription, or (3) is Insulin.

In addition to the requirements above, effective for expenses incurred on and after January 1, 2011 for over-the-counter drugs or medicine, the Participant must submit the prescription or a copy of the prescription or other documentation that a prescription has been issued. If the above required documentation is not provided for over-the counter drugs or products, such expenses will not be reimbursed under the Plan.

Notwithstanding anything herein to the contrary, all elections of coverage hereunder and the Employee's commitment to provide Medical Reimbursement Account expenses shall be made by an annual election and shall be based on the annual Coverage Period determined pursuant to the Enrollment Form.

Further, the amount of any Salary Reduction Medical Reimbursement Account expenses agreed to by the Participant shall be collected by the Employer per pay period pursuant to the Enrollment Form.

The maximum benefit payable to or on behalf of a Participant from the Medical Reimbursement Account for the Coverage Period shall not exceed the amount elected on the Enrollment Form which is attributable to the Medical Reimbursement Account, including any applicable Employer Credit Contribution. The Participant has other coverage available under a Health Care Plan of the Employer for the Coverage Period, and such other coverage is not limited to benefits that are excepted benefits under the Health Insurance Portability and Accountability Act.

5.02 Amount of Benefits

The maximum amount that may be elected to a Medical Reimbursement Account shall be the maximum amount identified in Appendix I. In addition, any amounts contributed to the Participant's Medical Reimbursement Account shall be subject to the following requirements:

(a) no interest shall be credited to such accounts;

(b) reimbursements shall be paid to the Participant following the submission of eligible expenses;

(c) funds may not be transferred between this and any other account;

(d) a Participant may submit eligible expenses incurred during the Coverage Period up to March 31 following the end of the Coverage Period; and

(e) any balance in the Participant's account as of the last day of the Coverage Period which is not used to provide reimbursement for Medical Expenses incurred during the Coverage Period shall be forfeited by the Participant and used by the Company to offset any losses of the Company under the Medical Reimbursement Account program, or to reduce costs of administration. Any further excess shall be used in any manner authorized by relevant law.

However, effective January 1, 2014, and subject to the conditions contained in this paragraph, Participants may carry over to the subsequent Coverage Period an amount, up to $500, in Participant's Medical Reimbursement Account remaining unreimbursed as of the end of the period for submitting eligible expenses (March 31). The amount carried over may be used only to pay or reimburse Medical Expenses incurred during the entire Coverage Period to which the amount is carried over. For purposes of this Section, the amount remaining unused shall be calculated after all Medical Expenses have been reimbursed as soon as administratively feasible after the end of the period for submitting eligible expenses. Notwithstanding the foregoing, this paragraph shall not apply for a given Coverage Period, and thus no carryover will be available, if the Plan also provides for a Grace Period as of the last day of the Plan Year from which amounts would be carried over, during which benefits or contributions remaining in a Participant's Medical Reimbursement Account as of the end of a Plan Year are available to pay or reimburse the Participant for Medical Expenses incurred after that Plan Year.

With respect to the carryover allowance described above, the amount that may be carried over to the following Coverage Period is equal to the lesser of (1) any unused amounts from the immediately preceding Coverage Period or (2) $500. Any unused amount in excess of $500 that remains unused as of the end of period

for submitting eligible expenses is forfeited. For ease of administration, reimbursements of all claims for expenses that are incurred in the current Coverage Period shall be treated as reimbursed first from unused amounts credited for the current Coverage Period and, only after exhausting these current Coverage Period amounts, as then reimbursed from unused amounts carried over from the preceding Coverage Period. Any unused amounts from the prior Coverage Period that are used to reimburse a current Coverage Period expense (a) reduce the amounts available to pay prior Coverage Period expenses during the period for submitting eligible expenses, (b) must be counted against the permitted carryover of up to $500, and (c) cannot exceed the permitted carryover.

5.03 Qualified Reservist Distributions (Optional)

Effective June 17, 2008, a Participant may request a Qualified Reservist Distribution of any unused balance in the Participant's Medical Reimbursement Account. For purposes of this provision a "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Medical Reimbursement Account if:

(a) such Participant was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and

(b) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such an arrangement for the plan year which includes the date of such order or call.

5.04 Qualified HSA Distributions

Qualified HSA Distributions, as defined by Code Section 106, are allowed, as provided in subsection (a), (b), and (c) below.

(a) Plan-Year-End Rollovers from Medical Reimbursement Account to HSA. A Participant with a balance in a Medical Reimbursement Account with a grace period at the end of the Medical Reimbursement Account Plan Year is treated as an eligible individual for HSA purposes as of the first day of the first month in the immediately following Plan Year that the individual has high deductible heath plan (HDHP) coverage on the first day of the month if:

(i) A Qualified HSA Distribution from the Medical Reimbursement Account has not been previously made on behalf of the Participant with respect to that particular Medical Reimbursement Account,
(ii) The Participant has HDHP coverage as of the first day of the month during which the Qualified HSA Distribution occurs, and is otherwise an eligible individual,

(iii) The Participant elects by the last day of the Plan Year to have the employer make a Qualified HSA Distribution from the Medical Reimbursement Account to the HSA of the Participant,

(iv) The Medical Reimbursement Account makes no reimbursements to the Participant after the last day of the Plan Year,

(v) The employer makes the Qualified HSA Distribution directly to the HSA trustee by the fifteenth day of the third calendar month following the end of the immediately preceding Plan Year, but after the Participant becomes HSA eligible,

(vi) The Qualified HSA Distribution from the Medical Reimbursement Account does not exceed the lesser of the balance of the Medical Reimbursement Account on (a) September 21, 2006, or (b) the date of such Distribution, and

(vii) Either (a) after the Qualified HSA Distribution there is a zero balance in the Medical Reimbursement Account, and the Participant is no longer a participant in any non-HSA compatible health plan or (b) effective on or before the date of the first Qualified HSA Distribution the Medical Reimbursement Account is converted to an HSA-compatible health FSA, as described in Rev. Rul. 2004-45, for all participants.

(b) Other HSA Rules. This Plan is amended (i) to eliminate any provision that ties the allowable HSA contribution amount to the HDHP deductible, so that the maximum HSA contribution becomes tied solely to the statutory maximum, (ii) to eliminate any contribution restriction applicable to an individual who enrolls in a HDHP mid-year, so that the individual may be HSA-eligible for the entire year, provided that certain limitations (which limitations do not apply to situations involving disability and death) are met with respect to the applicable 12-month testing, and (iii) to eliminate any negative impact of a Medical Reimbursement Account grace period on HSA eligibility for a Medical Reimbursement Account participant who has a zero balance as of the end of the Plan Year to which the grace period applies.

(c) December 31, 2011 Sunset. As required by Code Section 106(e)(2)(B), any and all Qualified HSA Distributions must be contributed by the Employer directly to a Participant's HSA before January 1, 2012.

ARTICLE VI

DEPENDENT CARE ACCOUNTS

6.01 Dependent Care Accounts

(a) Dependent Care Account benefits, if any, shall be provided to the extent permitted in Appendix I.

(b) The Dependent Care Accounts shall be used to reimburse each eligible Participant for dependent care expenses, as defined in Code Section 129, up to the maximum amount of such Dependent Care Account expenses elected on the Participant's Enrollment Form (which maximum amount shall include any available Employer Credit Contribution) and credited to the Participant's Dependent Care Account. A Participant may not be reimbursed for the amount of any dependent care expenses that have not yet been credited to the Participant's Dependent Care Account through Salary Reduction or through any Employer Credit Contribution.

(c) The amount contributed to this account shall be used to pay employment-related dependent care expenses for a Dependent child or children under the age of thirteen (13) or for the expenses of any other Dependent, which are necessary to enable the Participant to remain gainfully employed. Employment-related dependent care expenses shall include the amounts paid for expenses of a Participant for household services or for the care of an eligible Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more eligible Dependents with respect to such Participant, provided that:

(i) if such amounts are incurred outside the Participant's home at a facility that provides care for a fee, payment or grant for more than six individuals who do not usually reside at the facility, the facility must comply with all applicable state and local laws and regulations including licensing requirements, if any;

(ii) if such amounts are incurred outside the Participant's home for a Dependent who is not a Dependent child, such expenses must be incurred for the care of a Dependent who regularly spends at least 8 hours each day in the Participant's household; and

(iii) employment-related dependent care expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of nineteen (19), or to an individual for whom the Participant or the Participant's Spouse is allowed a personal exemption under IRC Section 151(c).

In order to be reimbursed under this account, a Participant shall complete a reimbursement form and submit a statement of the amount of the expenses that have been incurred. An expense shall be considered as incurred when the Participant is provided with the care that gives rise to the expense, and not when the Participant is formally billed or charged for, or pays for the care.

6.02 Amount of Benefits

The maximum amount that may be elected to a Dependent Care Account shall be the amount identified in Appendix I, but in no event shall a Participant's election exceed the lesser of:

(a) five thousand dollars ($5,000.00) (or twenty-five hundred dollars ($2,500.00) in the case of a separate return filed by a married Participant);

(b) in the case of an Employee who is not married at the close of the Employee's taxable year, the earned income of such Employee for such taxable year; or

(c) in the case of an Employee who is married at the close of such taxable year, the lesser of:

(i) the earned income [as defined in Code Section 32(c)(2)] of such Employee for such taxable year, or

(ii) the earned income of the Spouse of such Employee for such taxable year.

Amounts contributed to the Participant's Dependent Care Account shall be subject to the following requirements:

(a) no interest shall be credited to such accounts;

(b) reimbursements shall be paid to the Participant following the submission of eligible expenses;

(c) funds may not be transferred between this and any other accounts;

(d) a Participant may submit eligible expenses incurred during the Coverage Period up to March 31 following the end of the Coverage Period; and

(e) any balance in the Participant's account as of the last day of the Coverage Period which is not used to provide reimbursement for dependent care expenses incurred during the Coverage Period shall be forfeited by the Participant and used by the Company to reduce costs of administration. Any excess shall be used in any manner authorized by relevant law.

ARTICLE VII

ADMINISTRATION

7.01 Plan Administration

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

(a) to make and enforce such rules and regulations as the Committee deems necessary or proper for the efficient administration of the Plan;

(b) to interpret the Plan; the Committee's interpretations thereof rendered in good faith shall be final and conclusive on all persons claiming benefits under the Plan;

(c) to decide all questions of fact and/or law concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan; and

(d) to appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan.

Further, the Committee is empowered to limit or modify the elections of highly compensated employees, highly compensated individuals or key employees to the extent necessary to comply with any applicable non-discrimination requirements of the Code, however, any such limitation or modification shall be made in a uniform and consistent manner and shall not have the effect of circumventing any provision of the Code or other applicable law.

The Committee shall have the authority to allocate among its members or employees any of its duties and responsibilities under the Plan or may designate persons other than members or employees to carry out any of its duties and responsibilities. Any such designation shall carry with it the discretionary power of the Committee as set forth above, as to those duties and responsibilities that are so designated.

7.02 Fiduciaries

Each Fiduciary who is allocated specific duties or responsibilities under this Plan, or any Fiduciary who assumes such a position with this Plan shall discharge his duties for the exclusive benefit of the Participants and Dependents and for the exclusive purpose of providing such benefits as stipulated in such Plan to such Participants and Dependents or

defraying reasonable expenses of administering the Plan. Each Fiduciary, in carrying out such duties and responsibilities, shall act with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in exercising such authority or duties.

A Fiduciary may serve in more than one Fiduciary capacity and may employ one or more persons to render advice with regard to his Fiduciary responsibilities. If the Fiduciary is serving as such without compensation, all expenses reasonably incurred by such Fiduciary shall be reimbursed by the Company or by another Employer.

7.03 Insurance and Plans of Benefits

This Plan shall not affect the benefits provided through any contract of insurance nor shall it affect the terms of any insurance contract. An insurance company shall continue to have exclusive authority and discretion to interpret its contract and to manage and control any funds held by it to the extent permitted under the terms of any insurance contract with the Employer. Further, this Plan shall not affect the terms of any other programs of benefits, whether insured or self-funded.

7.04 Examination of Records

The Committee shall make available to each Participant such records as they pertain to the Participant, for examination at reasonable times during normal business hours.

7.05 Claims for Benefits and Appeal Process

Claims for Benefits

Any claim for benefits under this Plan is to be submitted to the entity that has been retained to provide claims administration, hereafter the Claims Administrator. Within 30 days after receipt by the Claims Administrator of a claim for reimbursement, the Plan will make reimbursement for Medical Care Expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied.

The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process

In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial to the Committee within 180 days after receipt of written notice of the denial. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or the Participant will lose the right to appeal the denial and the right to file a civil action in court as provided by ERISA. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing that the Committee review the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

The appeal will be reviewed by the Committee, and written comments, documents, records, and other information submitted by the Participant will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On

request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of the appeal. If the decision on review is adverse to the claimant, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, the claimant will be provided either the specific rule, guideline, protocol, or other similar criterion, or will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and the Participant will have the right to pursue his or her claim under ERISA, including the right to file a lawsuit.

The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

Notwithstanding the foregoing, any claim which arises under any insurance contract(s) or Health Care Plan or other employee benefit plan that is not a Flexible Spending Account covered by this Plan shall not be subject to review under this Plan.

ARTICLE VIII

PARTICIPATION BY OTHER EMPLOYERS

8.01 Adoption of Plan

With the consent of the Company, any Employer which is treated as a single employer with the Company under subsections (b), (c) or (m) of Section 414 of the Code, or a successor company thereto, may become a participating Employer under the Plan by

(a) taking such action as shall be necessary to adopt the Plan,

(b) filing with the Committee a copy of an executed adoption agreement in a form specified by the Company and attached to this Plan in Appendix II, and

(c) taking such other action as may be necessary or desirable to put the Plan into effect with respect to such Employer.

8.02 Withdrawal from Participation

Any Employer may withdraw from participating in the Plan at any time by filing with the Committee a copy of a resolution of its board of directors to that effect and giving notice of its intended withdrawal to the Company prior to the effective date of withdrawal. Notwithstanding the above, the Company may prohibit the withdrawal of an Employer if such withdrawal would cause the Plan satisfy any applicable requirement under the Code.

8.03 Company Authorized to Act for Employers

Each Employer which shall become a participating Employer pursuant to Section 8.01 shall be deemed to have appointed the Company to exercise on its behalf all of the powers and authorities hereby conferred upon the Company by the terms of the Plan, including, but not by way of limitation, the power to amend and terminate the Plan. The authority of the Company to act as such shall continue until such Employer shall withdraw from the Plan. Notwithstanding the foregoing, the Company shall not have the authority to amend the Adoption Agreement executed by another Employer.

ARTICLE IX

AMENDMENT OR TERMINATION OF PLAN

9.01 Amendment or Termination

The Company reserves the right to amend, modify, revoke or terminate the Plan at any time, in whole or in part, without the consent of any Participant or Dependent. The authority to make any such changes to the Plan rests with the Committee or the appropriate authorized officers or other representatives of the Company. An amendment shall be in writing. If terminated, so further Salary Reductions shall be made.

ARTICLE X

MISCELLANEOUS

10.01 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

10.02 Limitation on Participant Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

(a) to give any person any legal or equitable right against any Employer or the Committee, except as expressly provided herein or provided by law; or

(b) to create a contract of employment with any Participant, to obligate the Employer to continue the service of any participating Employee or to affect or modify his or her terms of employment in any way.

10.03 Governing Law

This Plan is governed by the Internal Revenue Code and the regulations issued thereunder, to the extent that the Code addresses a provision provided in the Plan. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. Portions of this Plan are also governed by the Employee Retirement Income Security Act. To the extent not addressed by the Code or otherwise preempted by federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of TX.

10.04 Severability

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

10.05 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan or in any way shall affect the Plan or the construction of any provision thereof.

10.06 Non-Gender Clause

Whenever used in this Plan, the masculine gender shall include the feminine and the plural form shall include the singular.

ARTICLE XI

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

11.01 Governing Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose individually identifiable health information that is protected by HIPAA (hereafter "protected health information" or "PHI"). The following HIPAA definition of PHI applies to this Plan.

11.02 Protected Health Information

Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provisions of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased. The Plan Sponsor shall have access to PHI from the Plan only as permitted herein or as otherwise required or permitted by HIPAA.

11.03 Provision of Protected Health Information to Plan Sponsor

(1) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(2) Permitted Uses and Disclosure of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that: summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a group health plan; and from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(3) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 11.03(5) below and obtaining written certification as further described below in Section 11.04 below, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Plan Sponsor,

provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan and having to do with payment and health care operations, including but not limited to activities such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

(4) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

(5) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan) Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

(i) 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 information 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 information infeasible.

(j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware. For this purpose, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

(6) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow the following to access PHI:_____ _____. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures or other special discipline procedure that may be created by the Privacy Officer.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor will ensure that the above provisions related to Adequate Separation are supported by reasonable and appropriate security measures to the extent that the designees above have access to electronic PHI.

11.04 Certification of Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 11.03(5) above, "Conditions of Disclosure for Plan Administration Purposes."

ARTICLE XII

ADOPTION OF THE PLAN

IN WITNESS WHEREOF, the following authorized representative of the Company has executed this Plan on this the 1st day of September 2020 to be effective the 1st day of January, 2020.

ATTEST: (SEAL)

By: Karen E. Goodman

City of Burleson

By:

Title: City Manager

Statement Regarding Optional Provision – Plan Section 5.03

The Company X does _____ does not adopt the optional provisions of Plan Section 5.03 regarding Qualified Reservist Distribution.

KAREN E. GOODMAN
Notary Public, State of Texas
Comm. Expires 08-24-2021
Notary ID 125391700

APPENDIX I

Maximum Amount of Medical Reimbursement Account Elective Contributions

Effective Date	Maximum Amount of Elective Contributions per Plan Year
01/01/2020	$2750

Maximum Amount of Dependent Care Account Elective Contributions

Effective Date	Maximum Amount of Elective Contributions per Plan Year
01/01/2020	$5000

APPENDIX II

ADOPTION AGREEMENT FOR THE
City of Burleson
FLEXIBLE SPENDING ACCOUNT PLAN

The authorized representative of City of Burleson whose name appears below hereby adopts the City of Burleson Flexible Spending Account Plan (the Plan) in accordance with Section 8.01 of the Plan as an adopting Employer this 1st day of September, 2020, to be effective the 1st day of January, 2020.

ATTEST: (SEAL)

By: Karen E. Goodman

KAREN E. GOODMAN
Notary Public, State of Texas
Comm. Expires 08-24-2021
Notary ID 125391700

City of Burleson

By: _____

Title: City Manager

City of Burleson
Flexible Spending Account Plan
Summary Plan Description

Effective as Amended and Restated January 1, 2020

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INTRODUCTION

City of Burleson has implemented a Section 125 Cafeteria Plan and a Flexible Spending Account Plan to enable you to purchase certain benefits on a pre-tax basis. The Flexible Spending Account Plan consists of two reimbursement accounts that are further described below.

If there is any difference between information described in this Summary Plan Description and the Plan's formal documentation, the formal documentation will control. The formal documentation is subject to rules, regulations, and interpretations under Section 125 of the Internal Revenue Code and other provisions of the Internal Revenue Code.

FLEXIBLE SPENDING ACCOUNTS

As benefit options under the City of Burleson Section 125 Cafeteria Plan, the City of Burleson Flexible Spending Account Plan enables you to use pre-tax dollars to pay for many medical and dependent care expenses. There are two separate reimbursement accounts available to you:

- Medical Reimbursement Account for qualifying medical, dental and vision expenses incurred by you and your eligible dependents; and

- Dependent Care Account for the costs of day care for your children or other eligible dependents.

Special rules apply to the types of expenses eligible for reimbursement under each account. This booklet provides guidelines for using these accounts and lists some of the eligible expenses. If you have questions about flexible spending accounts, contact City of Burleson.

ELIGIBILITY

Each Employee who normally performs services for the Employer of at least 30 hours per week may elect to participate in the Plan as of the beginning of the next following Coverage Period. Any Employee whose employment begins after the beginning of a Coverage Period may begin participation on the First day after the end of waiting period after completing 1 months of service with the Employer.

Annual Enrollment Period

An annual enrollment period will be scheduled by the Company prior to the beginning of each plan year. At that time you will receive enrollment materials describing the Flexible Spending Accounts and the other options available to you under the Plan.

If you decide to participate in one or both of the Flexible Spending Accounts, you must elect the total amount of your annual compensation you wish to deposit into each account during the next plan year. The amount you elect to deposit into the appropriate Flexible Spending Account will be deducted prorata from your pay beginning the first payday of the plan year. After an election

is made, it may not be modified until the next annual enrollment period unless there is a Change in Status or other IRS authorized event that allows an election change.

Change in Status Events

Rules of the Internal Revenue Code require that generally, you may not change the amount you are depositing to your Flexible Spending Account Plan until the next annual enrollment period. However, you will be allowed to make a change if the change is a *Change in Status Event* and the *Consistency Rule* is satisfied. Valid *Change in Status Events* include the following:

For both Medical Reimbursement and Dependent Care Accounts:

- Change in Employee's Legal Marital Status (marriage, divorce, annulment, legal separation or death of spouse).

- Change in Number of Dependents (events that change an employee's number of dependents, such as birth, adoption, placement for adoption or death).

- Change in Employment Status of Employee, Spouse or Dependent (any of the following that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, change in worksite, or a change from an eligible to an ineligible employment status or classification).

- Dependent Satisfies (or Ceases to Satisfy) Dependent Eligibility Requirements (events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as due to age, student status, or similar circumstances). Please note that, effective March 30, 2010, dependent children include your adult children until the child attains age 26, as required by the new health reform law.

Other *Change in Status Events* may be allowed if they are acceptable under interpretations of the Internal Revenue Code. If you have questions, please ask your Employer's benefits representative.

If you experience a *Change in Status Event* and desire to make a change, you must make the change no later than 30 days following the *Event*.

Consistency Rule

A change must be "on account of and correspond with" a *Change in Status Event*. To meet this requirement, the change that you wish to make must be on account of and correspond with a *Change in Status Event* that affects eligibility for coverage under an employer's plan. This rule is satisfied as to the Dependent Care Account if the *Change in Status Event* affects expenses under that Account, such as when the child becomes 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent

with" a *Change in Status Event* will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service. If you have questions, please ask your Employer's benefits representative.

Other Events That May Allow Election Changes

- Cost Changes. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. If the caregiver is a relative, no change is permitted.

- Significant Coverage Change/Curtailment. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. It may apply, for example, when there is a change in provider, or eligibility for state-funded school resulting in decreased need for child care expenses.

- Change in Coverage of Spouse or Dependent Under Other Employer's Plan. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. If there is a change in your, your spouse's, or your dependent's coverage under another employer's plan, you may be allowed to change your election under the Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

- Judgment, Decree, or Order. If a judgment, decree, or order (collectively called "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under the Employee Retirement Income Security Act) requires an employee to cover a child under the Medical Reimbursement Account, the employee may increase deposits to cover the child. Likewise, if the order requires another individual to provide coverage for the child and coverage is, in fact, provided, then the employee may reduce deposits.

- Medicare and Medicaid. If an employee, spouse, or dependent becomes entitled to Medicare or Medicaid (other than coverage only for pediatric vaccines), the employee may make a change to reduce deposits to the Medical Reimbursement Account to take into account Medicare or Medicaid. Likewise, if the employee, spouse, or dependent loses eligibility for coverage under Medicare or Medicaid, the employee may increase deposits to the Medical Reimbursement Account to take into account loss of that coverage.

Additionally, the Plan's Administrator may modify your election(s) downward during the plan year if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

HOW THE SPENDING ACCOUNTS WORK

You can use your Flexible Spending Accounts to pay for a variety of expenses related to medical care and dependent day care. You may participate in one account or both accounts, or you may decide not to participate at all.

The following describes the procedure:

- During the annual enrollment period you indicate the total amount you wish to deposit in each account during the coming year.

- The annual amount you elect will be divided evenly over the appropriate number of pay periods. Each pay period, an equal portion of the total amount will be deducted from your compensation and credited to the appropriate account(s).

- When you incur eligible expenses, you submit a reimbursement account claim form together with the original itemized bill or receipt or the explanation of benefits (EOB) form from your insurance carrier.

- In accordance with the Uniform Reimbursement Requirement for Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain reimbursement up to the amount you have elected to deposit into your Medical Reimbursement Account.

- Reimbursements for dependent day care expenses are allowed up to the amount actually in your Dependent Care Account at the time you submit your request. If your claim exceeds the amount currently available in your Dependent Care Account, you receive additional reimbursements as more money is deposited into your account through payroll deductions.

TAX ADVANTAGES

The cash compensation (wages) you receive from City of Burleson is taxable. However, when you allocate a portion of your compensation on a pre-tax basis to be used for payment of your benefits, your taxable income is reduced by the amount you have allocated to benefits. This allocation results in a reduction of federal and, in most cases, state income taxes.

You do not have to pay taxes on the money you receive as reimbursement of eligible medical or dependent care expenses from your Flexible Spending Account Plan.

Social Security/Other Benefits May Be Affected

Since you do not pay Social Security taxes on any compensation you deposit to your Medical Reimbursement Account or your Dependent Care Account, your future Social Security benefit could be slightly reduced. Although this reduction usually is quite small, it could occur if your compensation falls below the annual Social Security taxable wage base as revised each year. The resulting decrease in your taxable compensation could impact other benefits which may be available through your employer.

MEDICAL REIMBURSEMENT ACCOUNT

You can deposit between $'0.00 and $'2,750.00 of your compensation into your Medical Reimbursement Account each year. You can use the money in your account to reimburse yourself for any eligible medical expense for yourself or your dependents which has not been paid by any other benefit plan. For purposes of the Medical Reimbursement Account, eligible dependents include your spouse, your dependent children, and any other person who is your dependent for federal tax purposes (i.e., any person for whom you claim an exemption on your tax return). Please note that effective March 30, 2010, dependent children include your adult children until the child attains age 26, as required by the new health reform law.

Eligible Medical Expenses

Eligible medical expenses include most expenses that qualify as medical expenses under the Internal Revenue Code. A partial listing of eligible expenses includes the following; items marked with an asterisk (*) may require additional documentation or reimbursement may be limited to the difference between a normal item and a special need item:

Deductibles & Co-Payments

Dental Expenses:
- *Routine & Preventive Services*
- *X-Rays*
- *Orthodontia & Appliances*
- *Restorative & Major services including fillings, crowns, implants, bridges*
- *Dentures*
- *Periodontal Services*

Vision Care Expenses:
- *Exam (Optometrist or Ophthalmologist)*
- *Rx Glasses & Contact Lenses & Supplies*
- *Corrective Surgery (RK & Lasik)*

Prescription Drugs including prescription vitamins and birth control pills

Medical Equipment:
- *Wheelchairs or Lifts*
- *Crutches*
- *Oxygen Equipment & Supplies*
- *Air Purifier/Filters**
- *Special Beds or Mattresses**
- *Blood Pressure Monitor*
- *Glucose Monitor*

Diabetic Supplies including test strips and Insulin

Hearing Expenses including testing and hearing aids plus batteries and repairs

Counseling & Psychiatric Treatment:
- *Psychiatrists & Psychotherapists*
- *Psychologists*
- *Legal fees related to commitment of mentally ill person*
- *Excluded: marriage/family counseling*

Therapy:
- *Treatment for Alcoholism or Drug/Chemical Dependency*
- *Physical Therapy*
- *Speech Therapy*
- *Prescription Smoking Cessation*
- *Prescription Weight Loss program*

Physical Examinations:
- *School & Work Physicals*
- *Annual Physical Exam including pap smears, mammograms and prostate screening*

Assistance for Disabled Persons:
- *Braille or other special books/items or cost of specially equipping home or car for access by disabled person**
- *Guide animals (purchase & care)*
- *Special Alert Systems*

Fees & Services:
- *Physicians, Surgeons, Anesthesiologists, OB/Gyn, or other specialists*
- *Ambulance (Air & Ground)*
- *Nursing (including room & board)*
- *Fertility Treatment*
- *Sterilization & Reversals*
- *Legal Abortion*
- *Medically necessary cosmetic services (e.g., following accident or mastectomy, etc.)*
- *Chiropractic services*

Alternative/Holistic Services: medically necessary treatment by licensed or certified practitioners including acupuncture and massage therapy

Other:
- *Medical Records*
- *Travel necessary to seek medical treatment (limitations apply)*
- *Organ/Tissue Donation Expenses*
- *Special Diet**
- *Support Garments* & Wigs*
- *Orthotics*
- *Prosthesis, Artificial Limbs*
- *Orthopedic shoes**
- *Shipping & Handling charges*
- *Disability testing & consultations*

If you use the Medical Reimbursement Account to pay for a particular medical expense, *you cannot claim the same expense as a deduction on your income tax return.*

Effective for all expenses incurred on and after January 1, 2011, the costs for a medicine or a drug will be eligible for reimbursement only if the medicine or drug requires a prescription, is available without a prescription (an over-the-counter medicine or drug) and you obtain a prescription, or is Insulin.

If you receive a reimbursement from your Medical Reimbursement Account and reimbursement for the same expense through your medical or dental coverage or another health care plan, you must refund the reimbursement you received from your Medical Reimbursement Account to the Plan.

Medical Expenses Not Eligible for Reimbursement

Not all medical expenses are eligible for reimbursement from your Medical Reimbursement Account. Here are some examples of expenses which are not eligible for reimbursement:

- Cosmetic Expenditures (e.g., teeth whitening, dermabrasion, chemical peels or spider vein treatment)
- General Wellness expenses (e.g., health club dues, special foods and supplements, vitamins, exercise programs and equipment, or weight loss programs)
- Insurance Premiums (e.g., replacement insurance for contact lenses or other health plan policies)
- Other: Missed Appointment, Late Payment or Interest Charges

Submitting a Claim

You can submit a claim for an eligible medical expense at any time during the Plan Year. Obtain a Request For Medical Reimbursement form from the claims administrator or your benefits representative and attach a copy of the original itemized bill or receipt for an expense not covered under your medical, dental, or vision coverage, or the explanation of benefits from the insurance carrier. Reimbursements will be made at least monthly.

The money you deposit in your account for the Plan Year will be used to reimburse you for eligible expenses incurred in that year only. You incur an expense when the service is provided, and not when the bill is sent or payment is made. For example, as a general rule, if the Plan Year is the calendar year, and you had a physical exam in 2012 and paid for it in 2013, you cannot submit a claim for the cost to your 2013 Medical Reimbursement Account. You can continue to submit claims for eligible medical expenses incurred during the Plan Year until March 31 following the end of the Plan Year.

Notwithstanding the foregoing, note that your employer may adopt a grace period for Medical Reimbursement Accounts available under the Plan. If the employer adopts a grace period, then you may be able to be reimbursed for eligible medical expenses incurred and paid for during the first two months and fifteen days following the applicable Plan Year. For example, if your

employer has adopted a grace period, then you may be eligible to be reimbursed with funds you set aside in 2013 for medical expenses you incur up to March 15, 2014.

Alternatively, effective January 1, 2014, you may be eligible to carry over to the next Plan Year up to $500.00 remaining in your account as of the deadline for submitting claims. This carryover option is available *only* if your Plan does *not* have the grace period option discussed above. The funds carried over may be used to pay for eligible medical expenses incurred in the subsequent Plan Year only. If available, reimbursements will be made first from unused amounts credited for the current Plan Year, and, only after exhausting those current Plan Year amounts, then reimbursed from unused amounts carried over from the preceding Plan Year.

Your employer should discuss the availability of these options in its open enrollment materials. Please contact your employer's benefits representative to determine whether the Plan has a grace period or allows for carryovers.

Unused Balances

As a general rule, unless the carryover or grace period options apply, if you have any money left in your account at the end of the year, and you have not submitted claims for that money by the March 31 deadline, you will forfeit your unused balance unless you are eligible for the carryover option discussed above.

All forfeitures from Plan participants will be used by the employer to offset any losses it has incurred for benefit payments under the Medical Reimbursement Account Plan and/or to reduce costs of administering the Plan. After this, forfeitures may be used in any manner authorized by relevant law.

Note that your unused balance may be affected by either a grace period or a carryover option offered by your Employer. Please contact your Employer's benefits representative if you have further questions about what happens to your unused balance at the end of a Plan Year.

Qualified Reservist Distributors

Effective June 17, 2008, you may request a Qualified Reservist Distribution of any unused balance in your Medical Reimbursement Account.

A Qualified Reservist Distribution is a distribution of all or a portion of your Medical Reimbursement Account if:

- You were ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and

- The distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year you receive your order or call.

Qualified HSA Distributors

In certain circumstances you may be allowed a Qualified HSA Distribution.

A Qualified HSA Distribution is a one-time option that allows, in limited circumstances, you to request that your unused Medical Reimbursement Account be transferred to a Health Savings Account (HSA). You should review Section 5.04 of the Plan for further details. As required by Federal tax law, Qualified HSA Distributions are not allowed after December 31, 2011.

DEPENDENT CARE ACCOUNT

You can deposit between $'0.00 and $'5,000.00 of your compensation into your Dependent Care Account each year. (If you are married, and your spouse files a separate tax return, you can deposit only up to $2,500.) You can use the money in your account to reimburse yourself for dependent care costs which you incur so that you and your spouse (if any) can work. If you are married but your spouse does not work, he or she may be considered working during any month that he or she is a full-time student or is incapable of caring for himself or herself.

Special Rule

There are additional limits on the amount you can deposit to this account. The amount of your deposit cannot be greater than your income or your spouse's, whichever is lower. For example, if you earn $15,000 a year and your spouse earns $4,500, the maximum you can deposit for dependent care expenses is $4,500.

Under this special rule, if your spouse is a full-time student or is incapable of caring for himself or herself, he or she is assumed to have a monthly income of $250 if you have one eligible dependent, or $500 if you have two or more eligible dependents.

Eligible Dependent Care Expenses

You can use your Dependent Care Account to pay for dependent care expenses for qualifying individuals. A qualifying individual is:

- a child under age 13 whom you are entitled to claim as a dependent on your federal tax return; and/or

- a spouse or other dependent (e.g., your parent or your spouse's parent) who is physically or mentally incapable of self care, who has the same principal place of abode as the Participant for more than half of the taxable year, and who spends at least eight hours a day in your home. [Note that unless a technical correction is made to the Internal Revenue Code, effective as of January 1, 2005, such dependent must also have gross income that is less than the exemption amount ($3,900 in 2013).]

Eligible dependent care expenses may include expenses for:

- care at dependent care centers that meet all applicable state and local requirements and provide care for more than six individuals;

- day camps (not overnight camps);

- services from individuals (other than you or your spouse's dependent or child less than age 19) who provide care inside or outside your home;

- services of a housekeeper, maid, cook or similar employee, for that portion of the time which is related to the care of a qualified individual.

The caregiver may be a relative if he or she is at least 19 years old and is not someone you can claim as a dependent on your federal tax return. Expenses or fees related to education cannot be reimbursed. Other expenses not listed above that are authorized by the Internal Revenue Code may be reimbursed.

Tax Credit Versus Dependent Care Account

The federal government allows you to take a tax credit on your federal income tax return for qualified dependent care expenses. The difference between the Dependent Care Account and the tax credit is that the Dependent Care Account provides a reduction of your taxable income, while the tax credit offers a direct reduction of the amount of tax you pay.

Your individual financial circumstances will determine which method is best for you. You might wish to consult with a tax consultant or financial advisor before making a decision.

Submitting a Claim

You can submit a claim for an eligible dependent care expense at any time during the Plan Year. Obtain a No Wait Dependent Care Reimbursement form from the claims administrator or your benefits representative and attach the original itemized bill or receipt from the provider of services, showing the provider's Social Security number (or tax identification number), the dates of service and the amount. Reimbursement for eligible expenses will be processed within 24 hours after receipt of the claim.

The money you deposit in your account for the Plan Year will be used to reimburse you for eligible expenses incurred in that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. You can continue to submit claims for eligible dependent care expenses incurred during the Plan Year until March 31 following the end of the Plan Year.

Notwithstanding the foregoing, please note that your employer may adopt a grace period for Dependent Care Accounts available under the Plan. If the employer adopts a grace period, then you may be able to be reimbursed for dependent care expenses incurred and paid for during the two months and fifteen days following the applicable Plan Year. For example, if your employer has adopted a grace period, then you may be eligible to be reimbursed with funds you set aside

in 2012 for dependent care you incur up to March 15, 2013. Please contact your Employer's benefits representative to determine whether the Plan has a grace period for Dependent Care Accounts.

Unused Balances

If you have any money left in your account at the end of the year, and you have not submitted claims for that money by the March 31 deadline, you will forfeit your unused balance.

All forfeitures from Plan participants will be used by the employer to reduce costs of administering the Plan or may be used in any manner authorized by relevant law.

CHANGES TO EMPLOYEE'S STATUS

If your employment status changes, participation in each of the reimbursement accounts may be affected. The effects of certain changes are described below.

Medical Reimbursement Account

Your participation in the Medical Reimbursement Account would be affected as follows, based on the type of employment change involved.

- **Leave of absence under the FMLA.** Your deposits may continue for as long as you are on paid leave or, if the leave is unpaid, you may elect to continue under the Account and make deposits in a manner approved by your employer. You should discuss payment methods with your employer if you are on unpaid leave. If you wish, you can elect to cease making deposits while you are on FMLA leave. If you cease making deposits, you will not be considered a participant in the plan, and you will not receive reimbursement for expenses incurred during the time you were not a participant. When you return from FMLA leave, you can be reinstated in your account. If any generally applicable changes were made to the plan while you were out, those changes will also apply to you.

  Upon return from an FMLA leave during which coverage terminated, the Employer may require reinstatement into a health benefit that is a medical reimbursement spending account, provided that Employees on a non-FMLA leave are also required to be reinstated into the spending account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave. For example, if an Employee has elected $1,200 of annual coverage under a medical reimbursement account ($100 pre-tax funding monthly) and is on an FMLA leave during April, May, and June, during which coverage ceases, Employee on return from the leave in July may resume coverage at $1,200 by paying $150 per month from July through December. Alternatively,

the Employee may resume coverage at the reduced level of $900 annually by paying $100 per month from July through December.

- **Non-FMLA Leave of Absence.** If your employer's policies provide for a paid leave of absence that is not covered by the FMLA, your deposits continue as long as your salary continues. If your leave of absence is unpaid, you may have a permissible *Change in Status Event* that would allow you to discontinue your deposits and cease participation. Please refer to the section on "*Change in Status Events*." If you want to continue deposits even though you have had a *Change in Status*, those deposits would be made with after tax income. Upon return from a non-FMLA leave during which coverage terminated, the Employer may require reinstatement into a health benefit that is a medical reimbursement spending account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave.

- **Death.** In the event of your death, your deposits stop. However, your surviving dependents may submit for reimbursement, eligible expenses incurred prior to your death. Claims for eligible expenses incurred prior to your death must be submitted by March 31 following the close of the Plan Year.

- **Change to ineligible employment status.** Your deposits stop. However, you can continue to request reimbursement of eligible expenses incurred through the date of the employment status change. Claims must be submitted by March 31 following the close of the Plan Year.

- **Termination of employment.** Your deposits stop with the last paycheck you receive after termination. However, you may continue to request reimbursement of eligible expenses incurred through your termination date. Claims must be submitted by March 31 following the close of the Plan Year.

If the events described above cause a loss of coverage under the Medical Reimbursement Account, you may have experienced a "qualifying event" under COBRA. COBRA is generally applicable to employers who employ 20 or more employees. If COBRA applies and you lose coverage due to a qualifying event, then those who were covered under the Medical Reimbursement Account before the qualifying event may be able to continue participation in the Medical Reimbursement Account by timely electing and paying for COBRA coverage. In addition to the premium deposits, which will generally be made on an after-tax basis for COBRA coverage, a 2% administrative fee may be charged. See Exhibit A at the end of this Summary Plan Description for more information about COBRA. COBRA is not available if you have a negative account balance as of the qualifying event.

Dependent Care Account

A change in employment status would affect your participation in the Dependent Care Account generally the same way as listed above for the Medical Reimbursement Account with the following two exceptions:

(1) COBRA: Dependent Care Accounts are not considered health plans; therefore, federal COBRA regulations do not apply. Coverage or service dates may not be extended beyond your date of termination or date of death.

(2) Leave of Absence: If you take any leave of absence, you can cease your deposits only if the leave of absence also qualifies as a *Change in Status Event.* A leave of absence qualifies as a *Change in Status Event* only if it is unpaid. Please remember that an eligible dependent care expense is one that allows you and your spouse to work. If you or your spouse are not working, dependent care expenses incurred during that time may not be expenses that are properly reimbursable. For this reason, you may want to consider timely ceasing deposits if you take an unpaid leave of absence. If you choose to continue deposits, those deposits would be made on an after-tax basis.

MORE IMPORTANT FACTS ABOUT THE REIMBURSEMENT ACCOUNTS

The Plan is provided through and administered by your Company. Claims are administered by Flores & Associates, LLC, P.O. Box 31397, Charlotte, NC 28231-1397 (the "Claims Administrator.")

Plan Names

The City of Burleson Section 125 Cafeteria Plan and Flexible Spending Account Plan. The Flexible Spending Account Plan contains two component accounts: Medical Reimbursement Accounts and Dependent Care Accounts.

Plan Documents

City of Burleson' Plans are fully described in the Plans' legal documents. There is another booklet available to you that describes the Section 125 Cafeteria Plan. This booklet describes the major provisions of the Flexible Spending Account Plan in easy to understand terms. It is shorter and far less technical than the Plans' legal documents. If there is any conflict or inconsistency between this booklet and the Plans' legal documents, or if this booklet does not cover or only partially covers any provision in the legal documents, the Plans' legal documents govern. If you have any questions about the Plans or if you would like to examine the Plans' legal documents, contact City of Burleson. It is intended that the Plans will be administered in accordance with all relevant statutory and governmental authority. To the extent that any Plan provision is contrary to any statutory and governmental authority, such authority will govern operation of the Plans.

Effective Date

The effective date of each of the Plans is January 1, 2016.

Plan Sponsor/Plan Administrator

City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

The Plan Administrator has the discretionary authority to administer the Plan in all of its details, including determining eligibility for benefits and construing all terms of the plan. The Plan Administrator has the discretion to determine all questions of fact and/or law that may arise in connection with the administration of the Plan. The Plan Administrator may assign its duties to others. The function of claims administration, in accordance with the terms of the Plan documentation, has been assigned to the Claims Administrator.

Claims Administrator

Flores & Associates, LLC
P.O. Box 31397
Charlotte, NC 28231-1397
(704) 335-8211

Legal Service

The agent for service of legal process for the City of Burleson Flexible Spending Account Plan is:

Corporate Secretary
City of Burleson
141 W Renfro
Burleson, TX 76028

Service of legal process may also be made on the Plan Administrator.

Plan Number

501

Plan Sponsor's Identification Number

75-6000475

Plan Year

The Plan year begins on January 1 and ends on December 31.

Type of Plan

The Medical Reimbursement Account is a type of welfare plan under ERISA that reimburses eligible medical expenses that are not reimbursed from other sources. The Dependent Care Account is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Section 125 Cafeteria Plan is authorized by Section 125 of the Internal Revenue Code and allows payment for certain benefits on a pre-tax basis.

Sources of Contributions

Employees contribute to the plan through pre-tax dollars that are elected by the employee and authorized by the Section 125 Cafeteria Plan. Employees select the amount of their contributions, up to authorized limits. A minimum contribution may be required.

Benefit Payments

Benefits are paid from the employer's general assets. There is no independent source of funds or any insurance contract that guarantees the payment of benefits. For administrative convenience, the Claims Administrator processes all claims for reimbursements on behalf of the employer.

Qualified Medical Child Support Orders

If required by any Qualified Medical Child Support Order ("QMCSO") defined in ERISA Section 609(a), the Plan will extend benefit to a Participant's non-custodial child. Participants and beneficiaries can obtain from the Plan Administrator, without charge, a copy of procedures used for determining whether an order satisfies the requirements of ERISA.

Future of the Plans

City of Burleson intends to continue the Plan indefinitely. However, it reserves the right to change or to terminate the Plan, or to eliminate any benefit under the Plan, at any time without the consent of any participant or dependent. City of Burleson or any authorized officer or representative of City of Burleson can make changes to or terminate the Plan. You will be notified if any changes are made.

CLAIMS DECISIONS AND APPEALING A DENIED CLAIM

The following information is provided regarding claims and review procedures for benefit plans that are covered by the Employee Retirement Income Security Act ("ERISA"). It is based upon regulations issued by the U.S. Department of Labor. Only the Medical Reimbursement Account under this Plan is a benefit that is covered by ERISA.

Claims Decisions. Within 30 days after receipt of a claim, the Plan will make reimbursement for expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied. The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process. In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial within 180 days after receipt of written notice

of the denial. Your written request should be sent to the Claims Administrator, which will forward your request for review to the Plan Administrator. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil action in court as described under "Statement of ERISA Rights" below. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing for a review of the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to pursue your rights under ERISA, including your right to file a lawsuit, as described in the "Statement of ERISA Rights" below.

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding. The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

STATEMENT OF ERISA RIGHTS

If you are a Participant in the Medical Reimbursement Account Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at your Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, if any, and a copy of any latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Upon written request to the Plan Administrator, obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of any latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

COBRA Continuation Coverage

If your Employer is subject to COBRA, you may have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review Appendix A of this Summary Plan Description for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit under this Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or any latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the Plan's money (if the Plan is considered to have money), or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance With Your Questions

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

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

APPENDIX A—COBRA CONTINUATION OF COVERAGE
This Appendix A Applies Only if the Employer is Subject to COBRA

Introduction

Important information about rights you may have to COBRA continuation coverage are described below, including when COBRA coverage may be available to you and what you need to do to protect the right to receive it. As a general rule, COBRA applies to employers that normally employed 20 or more employees during the preceding calendar year.

COBRA coverage is a temporary continuation of group health coverage that is available to covered employees, spouses, and dependent children under certain circumstances when their group health coverage would otherwise end. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act.

This Plan will offer COBRA coverage if the employer is subject to COBRA, and the coverage that is offered will be the coverage required by law. Nothing in this explanation is intended to change the requirements of law.

Since Medical Reimbursement Accounts qualify in some regards as group health plans, qualified beneficiaries have the right to elect COBRA only in the event the Medical Reimbursement Account is "underspent." For an account to be underspent as of the date of the qualifying event, the qualified beneficiary must be able to receive a maximum benefit amount which is greater than the total amount of the COBRA contribution (example: an employee elects $1200 for the plan year and on 11/1 he terminates employment. He has contributed $1000 by the date of his termination but has submitted no claims. His COBRA payment through the end of the plan year would be $204 ($1200-$1000=$200 + 2% for COBRA administration costs). This account is underspent since the employee could receive a maximum benefit of $1200 for a COBRA contribution of $204. In determining the maximum amount of the benefit that a qualified beneficiary could receive during the remainder of the plan year, the Plan may deduct any reimbursable claims submitted before the date of the qualifying event.

COBRA will be offered only to those who have "underspent" their Medical Reimbursement Account.

What is COBRA coverage?

COBRA coverage is a continuation of group health plan coverage when that coverage would otherwise end because of certain events called "qualifying events." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person losing group health plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the group health plan is lost because of the qualifying event. Certain newborns and newly adopted children may also be qualified beneficiaries. This is discussed in more detail below under the heading called "Other Individuals Who May be Qualified Beneficiaries." The word "you" below

generally refers to each person covered by the group health plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the group health plan provides to other participants and beneficiaries who are not receiving COBRA coverage. If the coverage for others changes, it will change in the same way for those who have elected COBRA. Each qualified beneficiary who elects COBRA coverage will have the same rights and responsibilities, and will be subject to the same terms and conditions for coverage, as others who are covered by the group health plan but who have not elected COBRA (including any annual enrollment and special enrollment rights), except that those who elect COBRA must pay for the entire cost of COBRA coverage, plus an administrative fee.

The COBRA coverage under the Medical Reimbursement Account will consist of the coverage amount in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year.

Qualifying Events

If you are an employee, you will be entitled to elect COBRA if your account is underspent and you lose group health coverage under the terms of the Plan because of one of the following qualifying events:

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will be entitled to elect COBRA if the account is underspent and you lose group health coverage under the terms of the Plan because of any of the following qualifying events:

(1) Your spouse dies; or
(2) Your spouse's hours of employment are reduced; or
(3) Your spouse's employment ends for any reason (other than for gross misconduct); or
(4) You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
(5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will be entitled to elect COBRA if the account is underspent and you lose group health coverage under the Plan because of any of the following qualifying events:

(1) Your parent-employee dies; or
(2) Your parent-employee's hours of employment are reduced; or
(3) Your parent-employee's employment ends for any reason (other than for gross misconduct); or
(4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) Your parents become divorced or legally separated; or
(6) You no longer meet the group health plan's definition of a dependent child and are therefore no longer eligible.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been properly notified that a qualifying event has occurred. However, COBRA will only be made available to those who have "underspent" their accounts. When the qualifying event is the end of employment (other than for gross misconduct), the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. You need not provide notice of these particular events. However, you must give notice of other qualifying events, as explained below.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the group health plan as a result of the qualifying event. Notice can be given by the employee, by a qualified beneficiary, or by their representative.

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within the 60-day period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within the 60-day period described above, you will lose your right to elect COBRA.

After your notice has been received, you may be asked to provide additional information. For example, you may need to provide a copy of a divorce decree, a birth certificate, or a school transcript.

Electing COBRA Coverage

Once City of Burleson receives notice and satisfactory proof that a qualifying event has occurred, and determines that your account is "underspent," COBRA coverage will be offered to each qualified beneficiary who loses group health coverage because of the qualifying event. You will receive information about electing COBRA, and you should follow the instructions given.

Independent Election Rights

Each qualified beneficiary will have a separate and independent right to elect COBRA coverage under the group health plan that covered him or her on the day before the qualifying event. For example, if both the employee and spouse have the right to elect COBRA coverage, the employee can elect COBRA even if the spouse does not. If several dependent children have the right to elect COBRA, COBRA can be elected for only one, for some, or for all of the dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries. Also, a parent or legal guardian may elect COBRA on behalf of their minor dependent children.

60-Day Election Period

To elect COBRA, you must complete the election form that will be provided to you and timely return it as instructed. Under federal law, you have 60 days to elect COBRA. The 60-day period is measured from the later of the date coverage is lost under the terms of the Plan or the date of the COBRA election notice. If you want to elect COBRA, the election form must be properly completed, placed in an appropriate envelope with correct postage and correct address, and postmarked within the 60-day election period. If mailed, your election is considered to have been made on the date it is postmarked. The form should be mailed to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the election form to the Plan Administrator (your employer), within the 60-day period. If hand-delivered, your election is considered to have been made on the date that it is received.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage. You do not have to send any payment with your election form. Important information about paying for COBRA coverage is included below under the heading, "Cost of COBRA Coverage." (Information is also provided below about a special second election period for certain individuals eligible for Federal Trade Adjustment Assistance.)

If you reject COBRA coverage before the due date of the election form, you may change your mind as long as you furnish a completed election form before the end of the 60-day election period. However, if you do this, COBRA coverage will begin on the date you furnish the election form and not on the date that you lost coverage under the terms of the Plan as a result of the qualifying event.

Special Considerations in Deciding Whether to Elect COBRA Coverage

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under a federal law known as HIPAA that applies to most group health plans. First, if you have more than a 63-day gap in health coverage, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. Election of COBRA may help you not have a gap in your health coverage. Second, if you do not elect and take COBRA coverage for the maximum time it is available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions. Finally, you should take into account that HIPAA provides for special enrollment rights. Under HIPAA, individuals have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after group health coverage under your employer's group health plan ends because of a COBRA qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you take COBRA coverage for the maximum time it is available to you.

How Long Does COBRA Coverage Last?

As explained above, COBRA coverage is a temporary continuation of group health coverage. The COBRA coverage periods described below are maximum coverage periods. You should keep in mind that COBRA coverage can end early, as explained later under the heading, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, COBRA coverage under the Medical Reimbursement Account offered under this Plan can last up to the end of the plan year in which the qualifying event occurred and cannot be extended.

Employee's Medicare Entitlement Followed by End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before one of these qualifying events, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Medical Reimbursement Account offered under this Plan can last up to the end of the plan year in which the qualifying event occurred and cannot be extended.

Employee's Death, Entitlement to Medicare, Divorce, Legal Separation, or Child's Loss of Dependent Status.

When the qualifying event is the death of the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the terms of the Medical Reimbursement Account Plan, COBRA coverage can last up to the end of the plan year in which the qualifying event occurred and cannot be extended.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

The coverage periods described above are maximum coverage periods. COBRA coverage will automatically terminate before the end of the maximum coverage period if:

(1) Any required premium is not paid in full on time;
(2) A qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. You should provide notice if this other coverage begins, as explained below;
(3) A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA. You should provide notice if Medicare entitlement occurs, as explained below; or
(4) The employer ceases to provide any group health plan for its employees.

In addition to the above situations that would cause the COBRA maximum coverage period to end early, COBRA coverage will also end for any reason that the plan would terminate the coverage of a participant or beneficiary who is not receiving COBRA (such as for fraud or misrepresentation).

Notices to be Provided by Qualified Beneficiary if COBRA Ends Early Due to Other Group Health Plan Coverage or Medicare Entitlement

COBRA coverage will terminate (retroactively if necessary), as of the date it should have ended as allowed by COBRA, even if you have not provided the notices requested of you above in this Termination of COBRA Coverage section. You may have to repay all benefits that were paid by the plan for expenses incurred after the date COBRA should have terminated. So that you will not be put in this position, you should notify the Plan Administrator as soon as possible if a qualified beneficiary becomes covered by another group health plan as described in (2) above, or entitled to Medicare benefits as described in (3) above. You may notify the Plan Administrator in writing or by phone at the address and phone number given at the end of this explanation. Any additional procedures required by the Plan Administrator are attached.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated group health plan participant or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. (Example: If you have elected $20 per pay period for contribution to your Medical Reimbursement Account, you may elect to continue under COBRA by paying $20.40 for that same coverage.) Information is also provided below about special rules for certain individuals who may be eligible for a tax credit. Refer to the heading "Health Care Tax Credit."

Paying for COBRA Coverage

First Payment for COBRA Coverage

If you elect COBRA, you do not have to make a payment when you send in your COBRA election. However, you must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. (The date you elect COBRA is the date your COBRA election form is postmarked, if mailed; otherwise, the date your election is received at the office of the Plan Administrator.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the group health plan. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator at the address shown at the end of this explanation. You may also hand-deliver a payment to the office of the Plan Administrator at the address shown at the end of this explanation. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the group health plan would have otherwise terminated, up through the time you make the first payment. You are responsible for making sure that the amount of your first payment is correct. You should contact the Plan Administrator as shown at the end of this explanation to confirm the correct amount of your first payment.

Claims for reimbursement will not be paid until you have elected COBRA and made the premium payment.

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of coverage. These monthly payments are due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before its due date, your coverage will continue for that month without any break. You are responsible for making sure that your premium payments are made on time. You will not be

given notices of payments that are due. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the payment to the office of the Plan Administrator. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment, but your coverage is subject to being suspended as explained below.

If you make a monthly payment after its due date but before the end of the 30-day grace period for that month, your health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim you submit for reimbursement while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.

Other Individuals Who May be Qualified Beneficiaries

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is timely enrolled in the group health plan, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. The child must meet all other requirements for coverage and enrollment under the plan.

Special Rules for Federal Trade Adjustment Assistance

Special COBRA rights apply to employees who lost health coverage associated with their employment being adversely affected by international trade and who qualify for Trade Adjustment Assistance or Alternative Trade Adjustment Assistance. These employees are entitled to a second opportunity to elect COBRA, if they did not elect it during the initial 60-day election period. The second election period begins on the first day of the month in which you become eligible for trade adjustment assistance (or would be eligible except for the requirement to exhaust unemployment benefits). The second COBRA election period can last for up to 60 days, but the election must also be made within the six months immediately after the date group health coverage was originally lost. If you elect COBRA coverage during the second election

period, it is effective on the first day of the second election period and not on the date coverage was originally lost. However, the maximum period of COBRA coverage is still measured from the date of the original qualifying event. The maximum period of COBRA coverage under the Medical Reimbursement Account is through the end of the plan year in which the qualifying event occurred.

Healthcare Tax Credit

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (as described in the preceding heading) and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage.

If you have questions about these new tax provisions, you should call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

If You Have Questions

Questions about your rights under COBRA should be addressed to the Plan Administrator whose address and telephone number are provided at the end of this explanation. Questions about your rights under the Plan should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

Keep the Plan Informed of Address Changes

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be mailed to the Plan Administrator whose name and address are provided at the end of this information about COBRA. You should also keep for your records a copy of any notices you send about COBRA.

Plan Administrator

The name and address of the Plan Administrator is:
City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

COBRA Administrator

The name and address of the COBRA Administrator is:
City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

Continuation coverage under COBRA is at all times subject to the rules and regulations under COBRA. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

APPENDIX B – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A. Governing Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose individually identifiable health information that is protected by HIPAA (hereafter "protected health information" or "PHI"). The following HIPAA definition of PHI applies to this Plan.

B. Protected Health Information

Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted herein or as otherwise required or permitted by HIPAA.

C. Provision of Protected Health Information to Plan Sponsor

(1) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(2) Permitted Uses and Disclosure of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that: (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a group health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(3) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in subparagraph C.(5) below and obtaining written certification as further described below in Section D. below, the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Plan Sponsor,

provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan and having to do with payment and health care operations, including but not limited to activities such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

(4) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

(5) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan) Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
(e) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
(i) 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 information 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 information infeasible.
(j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other

than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware. For this purpose, "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

(6) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow access to PHI only as designated by the Plan Sponsor, and only for plan administration purposes. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures or other special discipline procedure that may be created by the Privacy Officer.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor will ensure that the above provisions related to Adequate Separation are supported by reasonable and appropriate security measures to the extent that the designees above have access to electronic PHI.

D. Certification of Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in subparagraph C.(5) above, "Conditions of Disclosure for Plan Administration Purposes."

City of Burleson
SECTION 105
HEALTH REIMBURSEMENT PLAN

PLAN DOCUMENT &
SUMMARY PLAN DESCRIPTION

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I. Introduction

City of Burleson, (the "Entity"), hereby establishes this Section 105 Health Reimbursement Plan ("Plan"), as an addition to its Medical Insurance Plan, in order to permit reimbursement of certain Medical Care Expenses. The Plan is intended to be a self-funded medical expense reimbursement plan under Code Section 105, so that all benefits payable hereunder are excluded from gross income. Employees do not contribute to the Plan, and this Plan does not interact with a Section 125 cafeteria plan in such a way to permit employees to use salary reduction to indirectly fund the Plan. In no event will benefits be provided in the form of cash or any other taxable or nontaxable benefit, except for reimbursement as provided in this Plan. The Plan shall not be deemed to constitute a contract between the Entity and any employee. Subject to the above, the Plan is governed by the terms, provisions and conditions described herein.

This Plan is intended to qualify as a health reimbursement arrangement as described in IRS Notice 2002-45 and Revenue Ruling 2002-41, and to comply with IRS Notice 2013-54 and shall be interpreted to accomplish those objectives. This Plan is being offered as an integrated Plan to Eligible Employees exclusively in conjunction with a group health plan providing minimum value pursuant to Section 36B(c)(2)(C)(ii) of the Internal Revenue Code.

The Plan is effective as of 12:01 a.m. on January 1, 2017.

II. Schedule of Benefits

Benefits available under the Plan are listed in Appendix A – HRA Diagram.

The HRA covers In-Network and Out-of-Network Deductible expenses.

The HRA will cover $1000 of deductible expenses for Individual Only coverage and $2000 of deductible expenses for Family coverage.

Individual coverage: $1000Family coverage: 2000

The Entity prior to the beginning of a new plan year may adjust the amount covered by this plan at its discretion.

Excluded Expenses

Any and all expenses excluded by the Group Health Plan. Mental Health and Chemical Dependency Expenses. The HRA also excludes any Dental or Vision expenses.

This Plan operates in conjunction with the Group Health Plan and pays Covered Expenses after satisfaction of the Covered Person prior to reimbursement, as shown in Appendix A.

III. Eligibility and Participation

Eligible Employee: The HRA covers In-Network and Out-of-Network Deductible expenses.

Eligible Dependents: Any dependent of the Eligible Employee, provided that said dependent is covered by the Group Health Plan as a dependent of the Eligible Employee.

An Eligible Employee, as well as his or her Eligible Dependents, will automatically become covered by this Plan upon becoming covered by the Group Health Plan.

Continuation During Leave of Absence

If the Entity is covered by the Family and Medical Leave Act ("FMLA") and if a Participant goes on an FMLA leave, coverage under this Plan shall continue if coverage continues under the Group Health Plan, as allowed by the FMLA. If the leave of absence is not covered by the FMLA for any reason, then coverage under this Plan shall continue if coverage under the Group Health Plan continues. Further, coverage under this Plan shall continue if required by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA").

IV. Reimbursement and Maximum Reimbursement Amount

This Plan will reimburse the Participant for Medical Care Expenses incurred by the Covered Person while covered by the Plan, subject to the following conditions per Benefit Year. An expense is incurred when the service is provided, and not when the bill is sent or payment is made to the provider.

1. The reimbursement amount shall be limited per Benefit Year to the Maximum Reimbursement Amount shown in Appendix A.

2. Before reimbursement by this Plan, the Covered Person Payment Prior to Reimbursement, as shown in Appendix A, must first be paid. This means that this Plan's reimbursement will be available only after the threshold as listed in Appendix A has been satisfied.

3. Any reimbursement under this Plan must be substantiated as requested by the Claims Administrator on a form or forms approved by the Claims Administrator.

4. No payment will be made hereunder to the extent that the expense has been reimbursed or is reimbursable to or on behalf of the Covered Person from any other source. Evidence that this requirement is satisfied must be substantiated as requested by the Claims Administrator.

The Maximum Reimbursement Amount shall be determined as of the beginning of the Benefit Year or, if later, the date Plan participation begins. In the event the Participant changes coverage options under the Group Health Plan during the Benefit Year (*e.g.,* changes from employee only coverage to employee and family coverage) and, as a result, his or her deductible under the Group Health Plan, the Maximum Reimbursement Amount under this Plan shall be adjusted accordingly, based on the date of the Change in Status. If participation in the Plan ends and begins again during the same Benefit Year, such as in the case of termination of employment followed by rehire, the prior Maximum Benefit Amount will be reinstated upon re-participation (reduced by any reimbursements from the Plan prior thereto) as though participation had not ended. A Participant is not entitled to receive payment for any unused portion of his or her Maximum Reimbursement Amount per Benefit Year.

V. Claims

a. You can submit a claim for reimbursement at any time during the Benefit Year. Obtain a claim form from the Claims Administrator or the Human Resources department. Attach an Explanation of Benefits from the Group Health Plan showing that the amount was not paid because it was applied to the deductible under the Group Health Plan. The Claims Administrator may request additional documentation in order to substantiate the claim. Approved reimbursements will be made Weekly. However, the Plan may require a minimum amount of submitted claims before a reimbursement will be made.

b. Submit your Explanation of Benefits (EOB), and the completed HRA Reimbursement Claim form to the Claims Administrator at:

c. Claims must be filed by March 31 after the end of the Benefit Year in which expenses were incurred. If not filed in a timely manner the Plan will not reimburse the expense.

d. Within 30 days after receipt by the Claims Administrator of a claim for reimbursement, the Plan will make reimbursement for Medical Care Expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied.

The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process

In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial to the Plan Administrator (the "Entity") within 180 days after receipt of written notice of the denial. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil action in court as described at Section XI, Rights of Employees Under ERISA. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing that the Plan Administrator review the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to pursue your rights under ERISA, including your right to file a lawsuit, as described in Section XI, Rights of Employees Under ERISA.

The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

VI. Termination of Participation

The coverage of any Covered Person shall terminate the earlier of the following dates:

a. The date the Plan terminates;

b. The date the Group Health Plan terminates; or

c. The date the Covered Person ceases to be covered by the Group Health Plan, unless coverage is continued under this Plan pursuant to a COBRA election.

When participation terminates, reimbursement will not be made for expenses incurred after termination of participation. A Participant may request reimbursement for expenses incurred prior to termination of participation, provided that a claim is filed within 90 days following the close of the Benefit Year in which participation ceased.

If the Entity is covered by COBRA, a Covered Person whose coverage terminates under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same

coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

Notwithstanding the foregoing, effective at the beginning of the 2014 Plan Year, and during every subsequent Plan Year, a Participant shall be permitted to opt out of the HRA and waive future reimbursements from the HRA once each year.

VII. Continuation of Coverage (COBRA) – This Section applies only if the Entity is subject to COBRA

Introduction

Important information about rights you may have to COBRA continuation coverage are described below, including when COBRA coverage may be available to you and what you need to do to protect the right to receive it. As a general rule, COBRA applies to employers that normally employed 20 or more employees during the preceding calendar year.

COBRA coverage is a temporary continuation of group health coverage that is available to covered employees, spouses, and dependent children under certain circumstances when their group health coverage would otherwise end. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act.

This Plan will offer COBRA coverage if the Entity is subject to COBRA, and the coverage that is offered will be the coverage required by law. Nothing in this explanation is intended to change the requirements of law.

What is COBRA coverage?

COBRA coverage is a continuation of group health plan coverage when that coverage would otherwise end because of certain events called "qualifying events." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person losing group health plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the group health plan is lost because of the qualifying event. Certain newborns and newly adopted children may also be qualified beneficiaries. This is discussed in more detail below under the heading called "Other Individuals Who May be Qualified Beneficiaries." The word "you" below generally refers to each person covered by the group health plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the group health plan provides to other participants and beneficiaries who are not receiving COBRA coverage. If the coverage for others changes, it will change in the same way for those who have elected COBRA. Each qualified beneficiary who elects COBRA coverage will have the same rights and responsibilities, and will be subject to the same terms and conditions for coverage, as others who are covered by the group health plan but who have not elected COBRA (including any annual enrollment and special enrollment rights), except that those who elect COBRA must pay for the entire cost of COBRA coverage, plus an administrative fee.

Qualifying Events

If you are an employee, you will be entitled to elect COBRA if you lose group health coverage under the terms of the Plan because of one of the following qualifying events:

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose group health coverage under the terms of the Plan because of any of the following qualifying events:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason (other than for gross misconduct); or
(4) You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
(5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose group health coverage under the Plan because of any of the following qualifying events:

(1) Your parent-employee dies;
(2) Your parent-employee's hours of employment are reduced;
(3) Your parent-employee's employment ends for any reason (other than for gross misconduct);
(4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) Your parents become divorced or legally separated; or
(6) You no longer meet the group health plan's definition of a dependent child and are therefore no longer eligible.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been properly notified that a qualifying event has occurred. When the qualifying event is the end of employment (other than for gross misconduct), the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. You need not provide notice of these particular events. However, you must give notice of other qualifying events, as explained below.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the group health plan as a result of the qualifying event. Notice can be given by the employee, by a qualified beneficiary, or by their representative.

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within the 60-day period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within the 60-day period described above, you will lose your right to elect COBRA.

After your notice has been received, you may be asked to provide additional information. For example, you may need to provide a copy of a divorce decree, a birth certificate, or a school transcript.

Electing COBRA Coverage

Once the Plan Administrator receives notice and satisfactory proof that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary who loses group health coverage because of the qualifying event. You will receive information about electing COBRA, and you should follow the instructions given.

Independent Election Rights

Each qualified beneficiary will have a separate and independent right to elect COBRA coverage under the group health plan that covered him or her on the day before the qualifying event. For example, if both the employee and spouse have the right to elect COBRA coverage, the employee can elect COBRA even if the spouse does not. If several dependent children have the right to elect COBRA, COBRA can be elected for only one, for some, or for all of the dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries. Also, a parent or legal guardian may elect COBRA on behalf of their minor dependent children.

60-Day Election Period

To elect COBRA, you must complete the election form that will be provided to you and timely return it as instructed. Under federal law, you have 60 days to elect COBRA. The 60-day period is measured from the later of the date coverage is lost under the terms of the Plan or the date of the COBRA election notice. If you want to elect COBRA, the election form must be properly completed, placed in an appropriate envelope with correct postage and correct address, and postmarked within the 60-day election period. If mailed, your election is considered to have been made on the date that it is postmarked. The form should be mailed to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the election form to the Plan Administrator (your employer), within the 60-day period. If hand-delivered, your election is considered to have been made on the date that it is received.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage. You do not have to send any payment with your election form. Important information about paying for COBRA coverage is included below under the heading, "Cost of COBRA Coverage." (Information is also provided below about a special second election period for certain individuals eligible for Federal Trade Adjustment Assistance.)

If you reject COBRA coverage before the due date of the election form, you may change your mind as long as you furnish a completed election form before the end of the 60-day election period. However, if you do this, COBRA coverage will begin on the date you furnish the election form and not on the date that you lost coverage under the terms of the Plan as a result of the qualifying event.

Special Considerations in Deciding Whether to Elect COBRA Coverage

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under a federal law known as HIPAA that applies to most group health plans. First, if you have more than a 63-day gap in health coverage, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. Election of COBRA may help you not have a gap in your health coverage. Second, if you do not elect and take COBRA coverage for the maximum time it is available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions. Finally, you

should take into account that HIPAA provides for special enrollment rights. Under HIPAA, individuals have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after group health coverage under your employer's group health plan ends because of a COBRA qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you take COBRA coverage for the maximum time it is available to you.

How Long Does COBRA Coverage Last?

As explained above, COBRA coverage is a temporary continuation of group health coverage. The COBRA coverage periods described below are maximum coverage periods. You should keep in mind that COBRA coverage can end early, as explained later under the heading, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, COBRA coverage generally can be continued for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period can be extended, described below under the heading "Extension of the 18-Month Period of COBRA Coverage."

Employee's Medicare Entitlement Followed by End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before one of these qualifying events, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage because of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates (for reasons other than gross misconduct), COBRA coverage under the group health plan for the employee's spouse and dependent children who lost coverage as a result of the employee's termination can last up to 36 months after the date of Medicare entitlement, which is 28 months after the qualifying event.

Employee's Death, Entitlement to Medicare, Divorce, Legal Separation, or Child's Loss of Dependent Status

When the qualifying event is the death of the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the terms of the group health plan, COBRA coverage can last for up to 36 months from the date of the qualifying event.

Extension of the 18-Month Period of COBRA Coverage

The 18-month maximum period of COBRA coverage described above when the qualifying event is the end of employment (except for gross misconduct) or reduction of hours, may be extended if: (1) a qualified beneficiary is disabled or (2) a second qualifying event occurs. You must notify the Plan Administrator of a disability or of a second qualifying event in order to be eligible to extend the period of COBRA coverage. Failure to provide notice will end the right to the extension. The opportunity to extend COBRA coverage does not apply if the original qualifying event resulted in up to 36 months of COBRA coverage. The extensions described below can end early as explained under the heading "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Disability Extension of the 18-Month Period of COBRA Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled, all of the qualified beneficiaries in your family may be entitled to receive an extension of up to an additional 11 months of COBRA coverage, for a total maximum of up to 29 months. To receive the extension, notice of the disability must be properly given as described below. Also, the disability must have started at some time before the 61st day after the employee's end of employment (except for gross misconduct) or reduction of hours, and the disability must last at least until the end of the original period of COBRA coverage.

You Must Provide Notice of the Disability

The disability extension is available only if you notify the Plan Administrator of the Social Security Administration's determination of disability. Your notice must be given within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination, (2) the date of the covered employee's end of employment or reduction of hours, or (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the group health plan as a result of the covered employee's end of employment or reduction of hours. You must also provide this notice within 18 months after the covered employee's end of employment or reduction of hours in order to be entitled to a disability extension.

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within both the 60-day period and the 18-month period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within both the 60-day and 18-month periods as described above, you will lose your right to a disability extension of COBRA coverage.

After your notice has been received, you may be required to provide additional information. For example, you may need to provide a copy of the Social Security Administration's determination of disability.

Notice of a disability can be given by the employee or former employee who is or was covered by the group health plan, by a qualified beneficiary, or by their representative.

Notice If the Disability Ends

If you receive an extension due to disability, and the Social Security Administration determines that the disability no longer exists, you must notify the Plan Administrator of that fact within 30 days after the date of the Social Security Administration's determination. COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the determination that the qualified beneficiary is no longer disabled. The Plan Administrator has the right to require repayment to the group health plan for all benefits paid after the date COBRA should have ended.

To provide this notice, you should send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within 30 days after the date of the Social Security Administration's determination. You must use an appropriate envelope with correct postage and the correct address. Note that it is to your advantage to send this notice earlier than 30 days since COBRA coverage will terminate retroactively to the date it should have ended as explained above. Providing the notice early will help avoid retroactive COBRA termination and the possibility that you will need to repay the group health plan for expenses incurred after the date COBRA should have ended. Any additional procedures required by the Plan Administrator are attached.

Second Qualifying Event Extension of the 18-Month Period of COBRA Coverage

An extension of COBRA coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or 29 months in the case of a disability extension) following the covered employee's end of employment or reduction of hours. The extension is up to 18 additional months, and the maximum amount of COBRA coverage available when a second qualifying event occurs is up to a total of 36 months. To receive the extension, notice of the second qualifying event must be properly given as described below. The second qualifying events may include the death of the employee or former employee who is or was covered by the group health plan, such employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation from such employee, or a dependent child ceasing to be eligible for coverage as a dependent under the terms of the group health plan. These events can be a second qualifying event only if the second event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred.

You Must Provide Notice of the Second Qualifying Event

This extension due to a second qualifying event is available only if you notify the Plan Administrator that a second qualifying event has occurred. Your notice must be given within 60 days after the later of: (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would lose coverage under the terms of the group health plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the group health plan).

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within the 60-day period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within the 60-day period described above, you will lose your right to an extension of COBRA coverage due to a second qualifying event.

After your notice has been received, you may be required to provide additional information. For example, you may need to provide a copy of a divorce decree, a death certificate, or a school transcript.

Notice can be given by the employee or former employee who is or was covered by the group health plan, by a qualified beneficiary, or by their representative.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

The coverage periods described above are maximum coverage periods. COBRA coverage will automatically terminate before the end of the maximum coverage period if:

(1) Any required premium is not paid in full on time;
(2) A qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. You should provide notice if this other coverage begins, as explained below;
(3) A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA. You should provide notice if Medicare entitlement occurs, as explained below;

(4) The employer ceases to provide any group health plan for its employees; or

(5) In the case of a disability extension, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled. You should provide notice if the Social Security Administration makes this determination, and you must do this no later than 30 days after the date of the determination (sooner if possible). See the explanation above under the heading, "Notice If the Disability Ends."

In addition to the above situations that would cause the COBRA maximum coverage period to end early, COBRA coverage will also end for any reason that the group health plan would terminate the coverage of a participant or beneficiary who is not receiving COBRA (such as for fraud or misrepresentation).

Notices to be Provided by Qualified Beneficiary if COBRA Ends Early Due to Other Group Health Plan Coverage or Medicare Entitlement

COBRA coverage will terminate (retroactively if necessary), as of the date it should have ended as allowed by COBRA, even if you have not provided the notices requested of you above in this Termination of COBRA Coverage section. You may have to repay all benefits that were paid by the group health plan for expenses incurred after the date COBRA should have terminated. So that you will not be put in this position, you should notify the Plan Administrator as soon as possible if a qualified beneficiary becomes covered by another group health plan as described in (2) above, entitled to Medicare benefits as described in (3) above, or ceases to be disabled, as described in (5) above. You may notify the Plan Administrator in writing or by phone at the address and phone number given at the end of this explanation. Any additional procedures required by the Plan Administrator are attached.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated group health plan participant or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. The amount of your COBRA premiums may change from time to time and will most likely increase over time. (Information is also provided below about special rules for certain individuals who may be eligible for a tax credit. Refer to the heading “Health Care Tax Credit.”)

Paying for COBRA Coverage

First Payment for COBRA Coverage

If you elect COBRA, you do not have to make a payment when you send in your COBRA election. However, you must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. (The date you elect COBRA is the date your COBRA election form is postmarked, if mailed; otherwise, the date your election is received at the office of the Plan Administrator**.**) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the group health plan. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator at the address shown at the end of this explanation. You may also hand-deliver payment to the office of the Plan Administrator. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the group health plan would have otherwise terminated, up through the time you make the first payment. You are

responsible for making sure that the amount of your first payment is correct. You should contact the Plan Administrator as shown at the end of this explanation to confirm the correct amount of your first payment.

Claims for reimbursement will not be paid until you have elected COBRA and made the premium payment.

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of coverage. These monthly payments are due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before its due date, your coverage will continue for that month without any break. You are responsible for making sure that your premium payments are made on time. You will not be given notices of payments that are due. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the payment to the office of the Plan Administrator. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment, but your coverage is subject to being suspended as explained below.

If you make a monthly payment after its due date but before the end of the 30-day grace period for that month, your health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim you submit for reimbursement while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.

Other Individuals Who May be Qualified Beneficiaries

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is timely enrolled in the group health plan, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. The child must meet all other requirements for coverage and enrollment under the plan.

Special Rules for Federal Trade Adjustment Assistance

Special COBRA rights apply to employees who lost health coverage associated with their employment being adversely affected by international trade and who qualify for Trade Adjustment Assistance or Alternative Trade Adjustment Assistance. These employees are entitled to a second opportunity to elect COBRA, if they did not elect it during the initial 60-day election period. The second election period begins on the first day of the month in which you become eligible for trade adjustment assistance (or would be eligible except for the requirement to exhaust unemployment benefits). The second COBRA election period can last for up to 60 days, but the election must also be made within the six months immediately after the date group health coverage was originally lost. If you elect COBRA coverage during the second

election period, it is effective on the first day of the second election period and not on the date coverage was originally lost. However, the maximum period of COBRA coverage is still measured from the date of the original qualifying event.

Healthcare Tax Credit

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (as described in the preceding heading) and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage.

If you have questions about these new tax provisions, you should call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

If You Have Questions

Questions about your rights under COBRA should be addressed to the Plan Administrator whose address and telephone number are provided at the end of this explanation. Questions about your rights under the Plan should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

Keep the Plan Informed of Address Changes

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be mailed to the Plan Administrator whose name and address are provided at the end of this information about COBRA. You should also keep for your records a copy of any notices you send about COBRA.

Plan Administrator

The name and address of the Plan Administrator is:
City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

Continuation coverage under COBRA is at all times subject to the rules and regulations under COBRA. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

VIII. Definitions

a. **Benefit Year:** The 12-month period used by the Group Health Plan for the measurement of satisfaction of the annual deductible amount for the Group Health plan. The Benefit Year is usually the calendar year, but refer to the Group Health Plan, which may use a period other than the calendar year to measure satisfaction of the annual deductible amount.

b. **Claims Administrator:** The Claims Administrator is Flores & Associates, LLC, 1218 S Church Street, Charlotte, NC 28203. The toll free number for the Administrator is: 800-532-3327.

c. **Code:** The Internal Revenue Code of 1986, as amended.

d. **Entity:** City of Burleson and any successor thereto who assumes the Plan.

e. **Covered Person**: An Eligible Employee or Eligible Dependent, as set forth in Section III who is covered by this Plan.

f. **ERISA:** The Employee Retirement Income Security Act of 1974, as amended.

g. **Group Health Plan:** The principal program of health benefits maintained by the Entity for its employees, their spouses and eligible dependents, and which provides major medical type benefits through a group insurance policy or policies.

h. **Medical Care Expenses.** Expenses incurred by a Covered Person for medical care as defined in Code § 213, but only to the extent all or a portion of such Expenses are payable by the Group Health Plan.

i. **Named Fiduciary:** The Entity.

j. **Participant:** An Eligible Employee who participates in the Plan.

k. **Plan:** City of Burleson Section 105 Health Reimbursement Plan, described herein.

l. **Plan Administrator**: The Entity.

m. **Plan Year:** 01/01/2020-12/31/2020

IX. Additional Information

Plan Administration and Authority of Plan Administrator
The operation of the Plan shall be under the control of the Plan Administrator, which shall carry out the Plan in accordance with its terms and intent, for the exclusive benefit of participants and beneficiaries. The Plan Administrator shall have full power and discretion to administer the Plan in all of its details, including but not limited to the power to (a) make and enforce rules as the Plan Administrator believes is necessary for the proper and efficient administration of the Plan, (b) interpret the Plan, including any ambiguous terms and including supplying any provisions that may have been omitted, said interpretation of the Plan Administrator being conclusive and binding on all persons claiming benefits under the Plan, (c) decide all questions of fact and/or law concerning the Plan and its administration, and the eligibility of any person to participate and receive benefits, and (d) appoint agents, counsel, or anyone else as may be required or helpful to administer the Plan.

The Plan Administrator has the authority to allocate among its members or employees any of its duties and responsibilities under the Plan, or the Plan Administrator may designate persons other than members or employees to carry out any of its duties and responsibilities.

Participation by Other Employers
As permitted by the Entity, any employer which is treated as a single employer with the Entity may become a participating employer under the Plan.

Amendment and Termination

The Entity reserves the right to amend, modify, revoke or terminate the Plan at any time and in any manner, without the consent of any participant or beneficiary. The authority to amend or terminate the Plan rests with the Entity and any duly authorized officers or other authorized representatives of the Entity. The persons with authority to amend or terminate the Plan include: Corporate Secretary>. An amendment shall be in writing.

Compliance with Federal Law
This Plan will comply with any applicable Federal law, including but not limited to any requirement under ERISA Sec. 609 to provide benefits in accordance with the terms of any qualified medical child support order. This Plan shall be operated in accordance with all applicable Federal laws, though such law may not be referenced herein.

X. Required Information for Summary Plan Descriptions

The above sections of the Plan (the plan document) and the information provided below (the summary plan description) are combined into this single document, intended to provide easy-to-understand explanations of the Plan's provisions. It is intended that the Plan be administered in accordance with all relevant laws. To the extent that any provision is contrary to applicable law (or is not included in the Plan), that law will govern as to its specific requirements.

Name of the Plan
City of Burleson Section 105 Health Reimbursement Plan.

Eligibility and Benefits Under the Plan
The requirements for eligibility, participation, and benefits are described in the preceding sections. The Plan reimburses limited medical expenses as described above. The procedures governing claims for benefits, for filing claim forms, and requesting an appeal and review of denied claims are described in the preceding sections. Circumstances that may result in ineligibility, loss of benefits, offset, etc. are described in the preceding pages. The previous pages also describe COBRA continuation coverage rights that are applicable if the Entity is subject to COBRA. Participants and beneficiaries can obtain, without charge, a copy of procedures governing qualified medical child support orders.

Employer Identification Number and Plan Number
The identification number assigned to the plan sponsor is 75-6000475

The Plan number is: 501

Plan Sponsor/Plan Administrator
City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

See the above Section IX regarding the discretionary authority of the Plan Administrator over the Plan and its operation. The Plan Administrator has delegated the function of claims administration to the entity named below.

Claims Administrator
Flores & Associates, LLC
Post Office Box 31397
Charlotte, NC 28231-1397
(704) 335-8211

Type of Plan
The Plan is authorized under Section 105(h) of the Internal Revenue Code; the Plan is also a welfare plan under ERISA. It reimburses specific medical expenses as described herein.

Plan's Records
Records are maintained for a Plan Year for the maximum number of years required by law.

Acceptance of Legal Notice
The Plan is a legal entity. Legal notices may be filed with, and legal process served as provided below. Service of legal process may also be made on the Plan Administrator.
City of Burleson
141 W Renfro
Burleson, TX 76028
8174269642

Future of the Plan
City of Burleson intends to continue this Plan indefinitely. However, the Entity reserves the right to change or terminate the Plan at any time without the consent of any participant or beneficiary. The Entity or any authorized officer or representative of the Entity can make changes to or terminate the Plan. The following officer(s) or representatives of the Entity may change or terminate the Plan: Corporate SecretaryCorporate Secretary. Participants will be appropriately notified of any changes or termination.

Cost of Coverage and Funding of the Plan
The Employer pays the full cost of the Plan. There are no employee contributions except as may be required to continue coverage under this Plan by electing COBRA, in which case, any employee contribution shall be made on an after-tax basis. All amounts paid as benefits under this Plan shall be paid from the general assets of the Entity.

XI. Rights of Employees Under ERISA

All Participants in the Plan are entitled to certain rights and protections under ERISA. You are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and any union halls, all documents governing the plan, including any insurance contract or collective bargaining agreement, and a copy of the latest annual report (if one is required) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefit Administration). You may obtain, upon written request to the plan administrator, copies of the above, as well as an updated summary plan description. The administrator may make a reasonable charge for copies. You may receive a summary of any annual financial report that ERISA may require.

Continue Group Health Plan Coverage
If your Entity is subject to COBRA, you may have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the terms of the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review prior provisions in this document on the rules governing your COBRA continuation coverage rights.

If covered by certain sections of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it

before losing coverage, or if you request it up to 24 months after losing coverage. The Plan will comply with any requirements that may apply under HIPAA.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon certain people who are responsible for the operation of the employee benefit plan. The people who operate your plan may be "fiduciaries"; and if they are fiduciaries, they have a duty to operate the plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules that are described in the preceding pages under the Claims section.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan (if an annual report is required) and you do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, provided that you have followed the claim and appeal procedure described at Section V above. If you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court, but you must follow the claims and appeals procedure described by the plan first. If it should happen that plan fiduciaries misuse the plan's money (if the plan is considered by the law to have money) or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Newborns' and Mothers' Health Protection Act of 1996
You should be aware that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

XII. Health Insurance Portability and Accountability Act (HIPAA)

A. Governing Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose individually identifiable health information that is protected by HIPAA (hereafter "protected health information" or "PHI"). The following HIPAA definition of PHI applies to this Plan.

B. Protected Health Information

Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provisions of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased. The Plan Sponsor shall have access to PHI from the Plan only as permitted herein or as otherwise required or permitted by HIPAA.

C. Provision of Protected Health Information to Plan Sponsor

(1) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(2) Permitted Uses and Disclosure of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that: summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a group health plan; and from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(3) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in subparagraph C.(5) below and obtaining written certification as further described in Section D. below**,** the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan and having to do with payment and health care operations, including but not limited to activities such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

(4) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

(5) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan) Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
(e) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
(i) 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 information 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 information infeasible.
(j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware. For this purpose, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

(6) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow the following to access PHI: President, Vice-President and Office Manager. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures or other special discipline procedure that may be created by the Privacy Officer.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor will ensure that the above provisions related to Adequate Separation are supported by reasonable and appropriate security measures to the extent that the designees above have access to electronic PHI.

D. Certification of Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in subparagraph C.(5) above, "Conditions of Disclosure for Plan Administration Purposes."

ADOPTION OF THE
City of Burleson
SECTION 105 HEALTH REIMBURSEMENT PLAN

The person whose signature appears below is properly authorized by City Council to adopt the City of Burleson Section 105 Health Reimbursement Plan and by his or her signature below does adopt said plan on behalf of the Entity, effective as of January 1, 2020.

This the 1st day of September, 2020.

City of Burleson

KAREN E. GOODMAN
Notary Public, State of Texas
Comm. Expires 08-24-2021
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Karen E. Goodman

By: _____

Title: City Manager

This is only a summary. For more information about your coverage, you can view the Legal Documents at **www.flores247.com** or call 1-800-532-3327.

Important Questions	Answers	Why This Matters:
What is the benefit available under the HRA?	Individual coverage: $1000Family coverage: 2000	The HRA will cover $1000 of deductible expenses for Individual Only coverage and $2000 of deductible expenses for Family coverage.
What is the overall deductible?	NA	You must pay all the costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1). Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses. HRA only reimburses certain eligible group health plan expenses.
Are there other deductibles for specific services?	N/A	No out-of –pocket limit applies to the HRA. Review the terms of your group health plan.
Is there an out-of-pocket limit on my expenses?	NA	No out-of-pocket limit applies to the HRA. Review the terms of your group health plan.
What is not included in the out-of-pocket limit?	N/A	No out-of –pocket limit applies to the HRA. Review the terms of your group health plan.
Does this plan use a network of providers?	N/A	No network of providers applies to the HRA. Review the terms of your group health plan.
Do I need a referral to see a specialist?	N/A	No referrals apply to the HRA. Review the terms of your group health plan.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses. HRA only reimburses certain eligible group health plan expenses.		
	Specialist visit			
	Other practitioner office visit			
	Preventive care/**screening**/immunization			
If you have a test	**Diagnostic test** (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fees			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	**Home health care**	Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses. HRA only reimburses certain eligible group health plan expenses.		
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Any and all expenses excluded by the Group Health Plan. Mental Health and Chemical Dependency Expenses. The HRA also excludes any Dental or Vision expenses.

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- No other services are covered by the HRA

Your Rights to Continue Coverage: Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for **claims** under your **plan**, you may be able to **appeal** or file a **grievance**. For more information about your rights, this notice, or assistance, contact Flores & Associates at 800-532-3327 or www.flores247.com.

Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?: Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses. HRA only reimburses certain eligible group health plan expenses.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-532-3327

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

These examples show how this **plan** might cover medical care in a few situations and show how **deductibles**, **copayments**, and **coinsurance** can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Patient Pays" section for the same example under each plan's Summary of Benefits and Coverage.

This is not a cost estimator. Don't use these examples to estimate your actual costs under this **plan**. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Also, costs don't include **premiums** you pay to buy coverage under a plan.

Having a baby
(normal delivery)

- **Cost of care** $14,150
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Hospital charges (mother)	$6,700
Routine obstetric care	$2,500
Hospital charges (baby)	$2,100
Anesthesia	$1,200
Laboratory tests	$1,000
Prescriptions	$200
Radiology	$200
Education	$200
Vaccines, other preventive	$50
Total	**$14,150**

Patient pays:

Deductibles/Copayments/ Coinsurance/ Limits or exclusions	$
Total	**$**

* The amount the patient pays in this example is determined by the terms of the group health plan. Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Cost of care** $6,100
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Prescriptions	$3,300
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$800
Education	$300
Laboratory tests	$200
Vaccines, other preventive	$200
Total	**$6,100**

Patient pays:

Deductibles/Copayments/ Coinsurance/ Limits or exclusions	$
Total	**$**

* The amount the patient pays in this example is determined by the terms of the group health plan. Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses.

Simple fracture
(with emergency room visit)

- **Cost of care** $2,400
- **Plan pays** $
- **Patient pays** $

Sample care costs:

Emergency Services	$1,400
Medical Equipment and Supplies	$400
Office Visits and Procedures	$300
Physical Therapy	$200
Laboratory tests	$90
Prescriptions	$10
Total	**$2,400**

Patient pays:

Deductibles/Copayments/ Coinsurance/ Limits or exclusions	$
Total	**$**

* The amount the patient pays in this example is determined by the terms of the group health plan. Please see your group health plan summary of benefits and coverage for the terms of coverage and covered medical expenses.