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Correspondence Memorandum

Date: July 30, 2019

To: Group Insurance Board

From: Xiong Vang, HSA & ERA Accounts Program Manager
Office of Strategic Health Policy

Subject: Section 125 Cafeteria Plan Approval

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve the Section 125 Cafeteria Plan Document, effective January 1, 2020.

Background

On February 20, 2019 the Board approved the Health Savings Account (HSA), Internal Revenue Code (IRC) Section 125 Cafeteria Plan and Employee Reimbursement Account (ERA), and Commuter Fringe Benefit Accounts contracts with ConnectYourCare® (CYC) for the period of May 1, 2019, through December 31, 2021, with the potential for two, two-year extensions (Ref. GIB| 5.15.19 | 2C).

While the recent requests for proposals included services related to general Cafeteria Plan Document annual updates and compliance, ETF did not receive vendor responses for these services. As a result, ETF informed the Board at the February 20, 2019 meeting that ETF would meet internally to determine how best to proceed with Cafeteria Plan Document updates.

ETF's Office of Legal Services (OLS) and Office of Strategic Health Policy (OSHP) have worked together to complete the necessary updates and compliance checks. Please find the results of these efforts in the Attachments, which include the following:

- Section 125 Cafeteria Plan Document (Attachment A)
- Cafeteria Plan Document Requirements Checklist (Attachment B)

Additional background information is provided below.

What is a Cafeteria Plan?

A cafeteria plan is a plan established in accordance with the requirements prescribed by IRC Section 125 and provides participants the option to pay for certain qualified benefit

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 8/5/19

Board	Mtg Date	Item #
GIB	8.21.19	8A

premiums pre-tax through a salary reduction agreement, reducing their taxable gross income. The Internal Revenue Services (IRS) requires a cafeteria plan document be established for accurate documentation of how a particular cafeteria plan works. The plan helps members and employers avoid compliance issues and possible adverse tax consequences. A cafeteria plan document provides a participant's rights and obligations under the plan.

A cafeteria plan must also contain annual non-discrimination testing (NDT) procedures. NDT checks for discrimination in favor of highly compensated employees.

The cafeteria plan serves as documentation for the qualified benefits offered through the plan. The following benefit plan premiums may be paid via pre-tax salary reductions through ETF's cafeteria plan:

- Health Care Flexible Spending Account
- Limited Purpose Flexible Spending Account
- Dependent Day Care Account
- Health Savings Account
- Group Health Insurance
- Group Life Insurance
- Supplemental Dental Insurance
- Vision Insurance

Revision of Cafeteria Plan

As noted above, ETF researched and drafted the attached Cafeteria Plan Document (Plan Document) to ensure compliance with state and federal law, and to include revisions necessary to onboard CYC as the third-party administrator of the HSA, FSA, LPFSA and the Dependent Daycare Program.[1] OSHP also provided the Plan Document to CYC for their review. These reviews resulted in the following updates:

- Clarified Article 1 definitions
- Current IRS limits on HSA, Health Care FSA, Limited Purpose FSA
- Amended and restated effective date
- Changed third-party administrator name
- Added component plans to Article V Premium Payment Plans
- Added component plan to Article VII Employee Life Insurance Plan

ETF will review certain Plan Document components annually or periodically to ensure compliance (See Table 1).

[1] CYC is also the TPA for Transit and Commuter Benefits under Internal Revenue Code Section 132. Federal law requires a separate plan document for Section 132 benefits.

Table 1. Annual and Periodic Changes to the Cafeteria Plan

	What change?	Where is it located?
Annual Changes	IRS limits on HSA contributions	Article 6.02
	IRS limits on HCFSA/LPFSA contributions	Article 6.04
	IRS limits on Dependent Day Care Account contributions	Article 6.06
	Amended and restated date will need to be updated anytime a change is made. Similarly, references to the year will need to be updated.	Page 1 of the Plan Document
Periodic Changes	Third-party administrator name and contact information when changes occur	Throughout the Plan Document
	Participating employers will be updated if any listed in 40.02 (54) stop participating or if employers not listed in 40.02 (54) start participating	Article 1.21
	Amended and restated date will need to be updated anytime a change is made	Page 1 of the Plan Document
	Changes in ETF contact information	Page 1 of the Plan Document

Roles and Responsibilities

The Board has oversight authority for the Section 125 Cafeteria Plan under Wis. Stats. §§ 40.03(6) & 40.85. CYC will take over administration of the HSA, ERA and Commuter Fringe Benefit Accounts on behalf of the Board effective January 1, 2020. CYC is responsible for producing compliant plan documentation and conducting non-discrimination testing each year. ETF will continue to work with CYC to oversee the maintenance of the plan documentation each year. In addition, a cafeteria plan document requirement checklist will be used to ensure the Plan Document follows IRC requirements prior to the Board's approval (see Attachment B).

ETF will inform the Board of updates made to the Plan Document on an annual basis.

Staff will be at the Board meeting to answer any questions.

Attachment A: Section 125 Cafeteria Plan Document
Attachment B: Cafeteria Plan Document Requirements Checklist

Attachment A: Section 125 Cafeteria Plan Document

STATE OF WISCONSIN

DEPARTMENT OF EMPLOYEE TRUST FUNDS

SECTION 125 CAFETERIA PLAN DOCUMENT

As Adopted Effective: January 1, 1990
Amended & Restated: June 1, 2019

Note: This document should be reviewed and approved by the Employer's legal counsel prior to being amended.

Wisconsin Department of Employee Trust Funds
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PREAMBLE

Effective January 1, 1990 (and as Amended and Restated on June 1, 2019), the State of Wisconsin, Department of Employee Trust Funds, established a Cafeteria Plan (the "Plan") for its Employees for purposes of providing Eligible Employees with the opportunity to choose from among the Benefit Plan Options available under the Plan. The Plan is designed to permit Eligible Employees to choose certain benefits instead of receiving cash compensation. The Plan is intended to qualify as a cafeteria plan under the provisions of Code § 125. This Plan has been established for the exclusive benefit of the Participants and their beneficiaries.

The following Benefit Plan Options are offered under the Plan as an alternative to receiving cash compensation:

- Health Premium Payment Plan
- Dental Premium Payment Plan
- Vision Premium Payment Plan
- Health Care Flexible Spending Account under Code sections 105, 106, and 125
- Limited Purpose Flexible Spending Account (in correlation with a HDHP and HSA) under Code section 223
- Health Savings Account (in correlation with a HDHP) under Code section 223
- Dependent Day Care Flexible Spending Account under Code section 129
- Employee Life Insurance Coverage Premium Plan

These Benefit Plan Options each have a separate, written Component Plan for purposes of administration and nondiscrimination requirements imposed by the Code. This Plan and the underlying benefits are intended not to discriminate with respect to contributions and benefits. In determining if any contribution or benefit hereunder is considered discriminatory, the rules in Code § 125 and the regulations thereunder will apply, as well as any other applicable Code sections or regulations.

As a non-federal governmental plan, this Plan is not subject to ERISA.

STATE OF WISCONSIN,
DEPARTMENT OF EMPLOYEE TRUST FUNDS
CAFETERIA PLAN

ARTICLE I: DEFINITIONS

1.01 "After-tax Contribution(s)"
means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement or Election Form after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan.

1.02 "Anniversary Date"
means the first day of any Plan Year.

1.03 "Benefit Plan Option(s)"
means those Qualified Benefits available to a Participant under this Plan as set forth in this Plan, as amended and/or restated from time to time.

1.04 "Board"
means the Group Insurance Board. The Board, upon adoption of this Plan, appoints the Plan Administrator to act on State Employers' behalf in all matters regarding the Plan.

1.05 "Change in Status"
means any of the events described more fully in Article 3 or the SPD, as well as any other events allowed under the law. Component Plans may contain their own requirements regarding a change in status.

1.06 "COBRA"
means the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as codified in Code section 4980B and Sections 601 through 607 of ERISA, or any successor legislation, as amended from time to time.

1.07 "Code"
means the Internal Revenue Code of 1986, as amended.

1.08 "Compensation"
means the cash wages or salary paid to an Employee by the Employer.

1.09 "Component Plan"
means the underlying written plan document governing one of the Benefit Plan Options offered by the Employer that Eligible Employees may elect to participate in through this Plan. Component Plans may contain additional eligibility requirements, benefit restrictions or limitations, claim and other administrative procedures, and other terms in addition to the terms of this Plan.

1.10 "Department"
means the State of Wisconsin, Department of Employee Trust Funds.

1.11 "Dependent"
means any individual who is a tax Dependent of the Participant as defined generally in Code Section 152; however, for health plan purposes (including any applicable Benefit Plan Option(s) and the Health Care FSA), a Dependent is defined as set forth in Code Section 105(b) including any child as defined in Code Section 152(f)(1) of the Participant who as of the end of the taxable year has not attained age twenty-seven (27)); and for DCFSA purposes (if offered under the Plan), a Dependent also means an individual described in Code Section 21(e)(5) (e.g., Dependent of the parent with custody for the greatest portion of the year). The individual Component Plans may have additional eligibility requirements, as provided under the terms of those plans, and the terms of this Plan are not intended to override any of those requirements.

1.12 "Dependent Day Care Flexible Spending Account" or "DCFSA"
means the Component Plan for reimbursing eligible dependent care expenses with Pretax dollars whose specific terms are set forth in Section 6.06 of this Plan.

1.13 "DPM"
means the Division of Personnel Management in the Wisconsin Department of Administration. Under Wis. Stats. § 40.05 (4) and § 40.515 (1) and (3), DPM is responsible for establishing the amount of non-elective contributions paid by Employers and the amount of contributions, if any, by Employers to HSA's as a part of a high-deductible health plan.

1.14 "Earned Income"
means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned Income does not include any amounts excluded from Earned Income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.15 "Effective Date"
Means [Date], the date the coverage went into effect for the benefit program.

1.16 "Elective Contributions"
means amounts elected by Participants to have deducted from their Compensation as contributions under a Component Plan for a Plan Year in exchange for certain benefits.

1.17 "Eligible Employee"
means any Employee described in Article II who is eligible to participate in one or more benefits under the terms of the Plan.

1.18 "Eligible Employment-Related Expenses"
means, for purposes of the DCFSA, those expenses that would be considered to be Employment-Related Expenses under Code § 21(b)(2) (relating to expenses for

household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code § 151(c)to the Participant or Participant's Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred.

1.19 "Eligible Medical Expenses"

means those expenses that are eligible for reimbursement under the Health Care FSA or HSA as set forth in this Plan and in the SPD, incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the relevant account and during the Plan Year to the extent that the expense satisfies the conditions set forth in this Plan and the SPD and are for medical care as defined by Code § 213(d). For purposes of this Plan, the following expenses are <u>not</u> considered Eligible Medical Expenses even if they otherwise constitute medical care under Code § 213(d):

i) Expenses for qualified long term care services (as defined in Code § 7702B); and
ii) Expenses for health insurance premiums; and
iii) Effective January 1, 2011, expenses for a medicine or drug unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.20 "Employee"

means an individual who the Employer classifies as a common-law Employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) an individual classified by the Employer as a contract worker or independent contractor; (b) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (c) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc.

1.21 "Employer" or "State Employer"

means the State of Wisconsin and any State of Wisconsin Employer under Wis. Stat. 40.02 (54) who adopts the Plan pursuant to authorization provided by the Employer. State Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. State Employers who have adopted the Plan are set forth in the SPD in Article 1.

1.22 "Entry Date"
means the date on which a Participant who elects to participate in a Component Plan starts participation for the Plan Year. Typically, the Entry Date is the first day of the Plan Year.

1.23 "Flexible Spending Account(s)" or "FSA(s)"
shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care FSA payments, LPFSA payments, and DCFSA payments to the extent adopted by the Employer as set forth in the SPD. No money shall actually be allocated to any individual participant account(s); any such account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the participant account(s).

1.24 "Health Care Flexible Spending Account" or "Health Care FSA"
means the Component Plan under which Participants may elect to use a specified amount of Pretax Contributions to be used for reimbursement of Eligible Medical Expenses, as set forth by Article VI of the Plan.

1.25 "Health Savings Account" or "HSA"
means the Component Plan under which Participants may elect to use a specified amount of Pretax Contributions to be used for reimbursement of Eligible Medical Expenses and other expenses allowed by federal law, as set forth by Article VI of the Plan. This account is intended to serve as a Health Savings Account under Section 223 of the Code.

1.26 "Highly Compensated Employee"
means any Employee who meets the definition under Code section 125 (e), 105 (h) (5), or 414 (a) as a "highly compensated participant," "highly compensated individual," or "highly compensated employee."

1.27 "HIPAA"
means the Health Insurance Portability and Accountability Act of 1996, or any successor legislation, as amended from time to time.

1.28 "Key Employee"
means any Employee who meets the definition under Code section 125 (b) (2) or 416 (i) (1).

1.29 "Limited Purpose Flexible Spending Account" or "LPFSA"
means the Component Plan under which Participants may elect to use a specified amount of Pretax Contributions to be used for reimbursement of Limited Eligible Health Care Expenses, in conjunction with a HDHP and HSA as set forth by Article VI of the Plan. This account is intended to serve as a combination limited purpose health FSA and post-deductible health FSA, as defined in Treasury Regulation Section 1.125-5 (m) (5).

1.30 "Limited Eligible Health Care Expenses"
means expenses that are eligible for reimbursement under the LPFSA as allowed by Treasury Regulation Section 1.125-5 (m), incurred by the Employee, or the Employee's

Spouse or Dependents, after the date of the Employee's participation in the LPFSA and during the Plan Year to the extent that the expense satisfies the conditions set forth in this Plan and the SPD. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.31 "Non-elective Contribution(s)"

means any amount which the Employer, at the direction of DPM or another appropriate authority provided in the Wisconsin statutes, may contribute on behalf of each Participant to provide benefits for Participants and their Dependents, if applicable, under one or more of the Benefit Plan Option(s) offered under the Plan. The amount of Employer contribution that is applied towards the cost of the Benefit Plan Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of DPM or another appropriate authority provided in the Wisconsin statutes, and may be adjusted upward or downward at DPM's or another appropriate authority's discretion, as provided in Wis. Stats. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as DPM or another appropriate authority shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Non-elective Contributions available to Participants and allow Participants to allocate the Non-elective Contributions among the various Benefit Plan Options offered under the Plan in a manner set forth in the SPD or enrollment material. In no event will any Non-elective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

1.32 "Participant"

means an Employee who becomes a Participant pursuant to Article II.

1.33 "Plan"

means this Cafeteria Plan as set forth herein, including any and all amendments and supplements, as may be adopted from time to time, which shall automatically become incorporated into and form part of this Plan document for so long as they remain in effect

1.34 "Plan Administrator" or "Administrator"

means the Department or other person(s) appointed by the Board with the authority, discretion and responsibility to manage and direct the operation and administration of the Plan.

1.35 "Plan Year"

means the Plan's 12 month account period, which begins on January 1 and ends on December 31.

1.36 "Pretax Contribution(s)" or "Pretax"

means any amount withheld from the Employee's Compensation pursuant to a Salary Reduction Agreement or Election Form before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the plan. This amount shall not exceed the premiums

or contributions attributable to the most costly Benefit Plan Option afforded hereunder, and for purposes of Code § 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.37 "Qualified Benefit"
means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations.

1.38 "Qualifying Individual"
means, for purposes of the DCFSA:

a) An individual under the age of 13 who is a "qualifying child" of the Employee as defined in Code Section 152(a)(1). Generally speaking, a "qualifying child" is a child (including a brother, sister, step sibling) of the Employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the same principal place of abode with the Employee for more than half the year and does not provide over half of his/her support. A child of divorced parents is a "qualifying child" of the Employee if the Employee is the custodial parent, as defined in Code Section 152.

b) A Spouse or other tax Dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Employee for more than half of the year.

1.39 "Qualifying Services"
means, for purposes of the DCFSA, services relating to the care of a Qualifying Individual that enable Participants or their Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility) the center must comply with all applicable state and local laws and regulations.

1.40 "Salary Reduction Agreement" or "Election Form"
means the actual or deemed agreement pursuant to which Eligible Employees or Participants elect to contribute their share of the cost of chosen Benefit Plan Options with Pretax or After-tax Contributions (if offered under the Plan) in accordance with Article III herein. If the Employer utilizes a web-based program for enrollment, the Salary Reduction Agreement or Election Form may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.41 "Spouse"

means an individual who is legally married to a Participant (and who is treated as a Spouse under the Code), but for purposes of the DCFSA Plan provisions, shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

1.42 "Summary Plan Description" or "SPD"

means the Cafeteria Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and associated with this Plan Document, and as amended from time to time. The SPD and appendices are incorporated hereto by reference.

1.43 "Student"

means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full-time Student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled Student body in attendance at the location where its educational activities are regularly presented.

1.44 "Third Party Administrator" or "TPA"

means an organization selected under Section 8.02 to assist in administration of this Plan. The current TPA is ConnectYourCare; more information about the TPA can be found in the SPD.

ARTICLE II: ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate.

All Employees are eligible to participate in the Plan on the first of the month that begins on or after the date the enrollment form is received by their Employer. The individual Component Plans may have additional eligibility requirements, as provided under the terms of those plans, and the terms of this Plan are not intended to override any of those requirements. Eligibility to participate in this Plan means only that the Eligible Employee is entitled to contribute his or her share of the cost of applicable Benefit Plan Options for which he is eligible with Pretax Contributions.

2.02 Effective Date of Participation.

The coverage date will be effective on the first of the month following a request for enrollment. The individual Component Plans may have additional eligibility requirements, as provided under the terms of those plans, and the terms of this Plan are not intended to override any of those requirements. Commencement of participation in the Plan is contingent on the Employee properly completing and submitting a Salary Reduction Agreement or Election Form.

2.03 Termination of Participation.

Participation shall terminate when the Participant ceases to be an Eligible Employee for any reason (such as termination of employment, failure to satisfy eligibility requirements, etc.) or elects to not participate in the Plan, except as provided otherwise in this Plan. Notwithstanding any provision in the Plan to the contrary, to the extent required by COBRA, Participants and their Spouses and Dependents whose coverage terminates under a Component Plan that is a group health plan because of a COBRA qualifying event will be given the opportunity to continue the same coverage that was in effect on the day before the qualifying event for the period prescribed by COBRA, subject to all conditions and limitations under COBRA.

2.04 Reinstatement of Former Participant.

A former Participant who returns to employment with the Employer within 30 days after a cessation of employment (and within the same Plan Year) will continue participation in the Plan under the same elections as were in effect prior to the cessation of employment and will not be treated as having experienced a change in employment status.

2.05 Leaves of Absence

Participants who take a leave of absence under the Family Medical Leave Act, under the Uniform Services Employment (or Wis. Stats. 40.05 (4g)) or Reemployment Rights Act, or as otherwise as approved by the Employer may continue their coverage under the Plan and under the Component Plans in accordance with, and to the extent permitted under, the terms thereof and in any case as required under applicable law. If the period of leave is unpaid, to the extent required by applicable law or as otherwise permitted by the Employer, the Employee will have the option to (i) pay any applicable Elective Contributions over the leave period with after-tax dollars (such payments to be made in advance for periods of coverage within a single Plan Year) and/or (ii) if timely elected prior to the period of leave, to pre-pay all or a portion of such Elective Contributions for the remaining portion of the Plan Year in which the leave begins through Compensation

reduction on a Pretax basis out of preleave Compensation (including unused paid time off). Nothing herein shall preclude alternative methods for funding Elective Contributions agreed upon by the Participant and the Administrator; provided that in no event shall any Compensation reduction for Participant Elective Contributions be applied to Compensation first made available to the Participant on a date prior to the related election.

ARTICLE III: BENEFIT ELECTIONS

3.01 Election of Contributions.

A Participant may elect any combination of Pretax Contributions or After-tax Contributions (to the extent set forth in the enrollment material) to fund any Benefit Plan Option available under the Plan, provided that only Qualified Benefits may be funded with Pretax Contributions. DPM or another appropriate authority provided in the Wisconsin statutes may allocate Non-elective Contributions to one or more Benefit Plan Options offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate their allotted share of Non-elective Contributions among the various Benefit Plan Options in a manner set forth in the SPD or enrollment material.

3.02 Initial Election Period.

(a) Currently Eligible Employees. An Employee who is eligible to become a Participant in this Plan as of the Effective Date must complete, sign and file a Salary Reduction Agreement or Election Form with the Plan Administrator (or its designated TPA as set forth on the Salary Reduction Agreement or Election Form) during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial Salary Reduction Agreement or Election Form shall be effective, subject to Sections 3.04 and 3.05, for the Plan Year beginning on the Effective Date.

(b) New Employees and Employees Who Have Not Yet Satisfied the Plan's Waiting Period. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date must complete, sign and file a Salary Reduction Agreement or Election Form with the Plan Administrator (or its designated TPA as set forth on the Salary Reduction Agreement or Election Form) within 30 days of the first possible coverage date. Participation will commence under this Plan as set forth in Article II, Section 2.02. Coverage under the Component Plans will be effective in accordance with the governing provisions of such Component Plans (but in no event prior to the election).

(c) Failure to Elect. An eligible Employee who fails to complete, sign and file a Salary Reduction Agreement or Election Form in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 Annual Election Period.

Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his or her right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the "Annual Election Period." The date on which the Annual Election Period commences and ends will be determined annually by the Board and will appear in enrollment material provided to Employees on an annual basis. Further instructions regarding how to make elections will be provided to

employees in this enrollment material. Participants may change their elections during this Annual Election Period.

3.04 Change of Elections Outside of Annual Election Period.

Elections are irrevocable. A Participant shall not make any changes to the Pretax Contribution amount or, where applicable, to the Participant's elected allocation of Non-elective Contributions outside of the Annual Election Period except for the occurrence of a valid Change in Status, changes required by certain judgments, decrees and orders, changes to Medicare or Medicaid eligibility, certain changes in cost or coverage, and changes pursuant to the Family and Medical Leave Act. For changes related to a Change in Status event, change in cost event, or change in coverage event, Participants must complete and submit a written change of election form within 30 days after the event occurs. HSAs are subject to different change of elections rules, as stated in Section 6.02.

Except for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child (as described in the SPD), all election changes shall be effective on a prospective basis only and will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed. As determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later.

The circumstances under which a Participant may change elections under this Plan are described here: Appendix 1 - Cafeteria Plan Life Events Matrix

Elections automatically terminate if Participant terminates employment or loses eligibility under the Plan or under a Component Plan that Participant has chosen.

3.05 Impact of Termination of Employment on Election or Cessation of Eligibility.

Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement or Election Form, except as provided otherwise in this Plan.

ARTICLE IV: PLAN CONTRIBUTIONS AND FUNDING

4.01 Source of Benefit Funding.

The cost of coverage under the component Benefit Plan Options shall be funded by Participant's Pretax and/or After-tax Contributions and/or any Non-elective Contributions provided by the Employer. The required contributions for each Benefit Plan Option offered under the plan shall be made known to Employees in enrollment materials. Pretax or After-tax Contributions (as elected by the Employee on the Salary Reduction Agreement or Election Form and permitted by the Employer) shall equal the contributions required from the Participant less any available Non-elective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Plan Options elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pretax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pretax Contributions, plus any Non-elective Contribution made available by the Employer, shall not exceed the aggregate cost of the Benefit Plan Options elected. The maximum amount of all benefits selected by a Participant may not exceed the sum of the aggregate premium and/or contribution for all Benefit Plan Options.

4.02 Cash Benefit.

To the extent that a Participant does not elect to have the maximum amount of his or her Compensation contributed as a Pretax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided however, that any applicable Non-elective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

4.03 Reduction of Certain Elections to Prevent Discrimination.

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pretax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

ARTICLE V: PREMIUM PAYMENT PLANS

5.01 Health Coverage Election.
Employees may elect, in accordance with the procedures of the Component Plan, to participate in the Employer health plan for a Plan Year or to waive such coverage.

5.02 Pretax Payment Feature: Health.
For Employees who elected health coverage under the Component Plan, they may choose to become Participants in the Plan under the processes of Article III, to have their premiums for health coverage taken Pretax out of their compensation. By making this choice, Participants agree to have their Compensation reduced to make these Elective Contributions. Employers shall reduce the Participant's Compensation over the applicable Plan Year in an amount equal to the Participant's share of the cost of premiums for the elected health plan. If Participant's participation in the Component Plan terminates during a Plan Year, Compensation reductions will stop. It is the intention that the benefits provided under this Component Plan will be eligible for exclusion from gross income of Participants under Code sections 105, 106, and 125, and that the Elective Contributions will be made on a Pretax basis for federal tax purposes.

5.03 Health Plan Benefits and Terms.
The benefits available under and governing terms of the health plans shall be as set forth in the Component Plan for each health plan. These Component Plans may contain requirements regarding eligibility and participation, and other terms, conditions, and limitations of coverage and benefits. To the extent there is conflict between the terms of this Plan and the Component Plan, the terms of the Component Plan shall govern, unless otherwise required to comply with the law. All requests for payment or benefits and appeals of denied claims are subject to the claim and review procedures set forth the in corresponding Component Plan.

5.04 Dental and Vision Coverage Elections.
Employees may elect, in accordance with the procedures of the Component Plans, to participate in dental and/or vision plans for a Plan Year or to waive such coverage.

5.05 Pretax Payment Feature: Dental and Vision.
For Employees who elected dental and/or vision coverage under the Component Plans, they may choose to become Participants in the Plan under the processes of Article III, to have their premiums for dental and/or vision coverage taken Pretax out of their compensation. By making this choice, Participants agree to have their Compensation reduced to make these Elective Contributions. Employers shall reduce the Participant's Compensation over the applicable Plan Year in an amount equal to the Participant's share of the cost of premiums for the elected health plan. If Participant's participation in the Component Plan terminates during a Plan Year, Compensation reductions will stop. It is the intention that the benefits provided under these Component Plans will be eligible for exclusion from gross income under Code section 125 through this Plan, and that the Elective Contributions will be made on a Pretax basis for federal tax purposes.

5.06 Dental and Vision Plan Benefits and Terms.

The benefits available under and governing terms of the dental and vision plans shall be as set forth in the Component Plans. The Component Plans may contain requirements regarding eligibility and participation, and other terms, conditions, and limitations of coverage and benefits. To the extent there is conflict between the terms of this Plan and the Component Plans, the terms of the Component Plans shall govern, unless otherwise required to comply with the law. All requests for payment or benefits and appeals of denied claims are subject to the claim and review procedures set forth the in corresponding Component Plans.

ARTICLE VI: SPENDING ACCOUNTS

6.01 Health Care FSA and LPFSA Reimbursement.

Each Participant's Health Care FSA or LPFSA will be credited with amounts withheld from the Participant's Compensation as selected through the procedures in Article III and any Non-elective Contributions allocated thereto by the Employer. By electing to participate in this benefit, Participants agree to have their Compensation reduced to make the applicable Elective Contributions. The purpose of the accounts is to cover Eligible Medical Expenses and Limited Eligible Health Care Expenses. The account will be debited for health care reimbursements disbursed to the Participant in accordance with this Article VI. The entire amount elected by the Participant on the Salary Reduction Agreement or Election Form as an annual amount for the Plan Year for health care reimbursement less any health care reimbursements already disbursed to the participant for Expenses incurred during the Plan Year shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care FSA or LPFSA (provided that the periodic contributions have been made). Thus, the maximum amount of health care reimbursement at any particular time during the Plan Year will not be related to the amount that a Participant has had credited to his or her Health Care FSA or LPFSA. In no event will the amount of health care reimbursements in any Plan Year exceed the annual amount specified for the Plan Year in the Salary Reduction Agreement or Election Form for health care reimbursement or exceed the applicable contribution limits announced by the Internal Revenue Service for the year. Amounts forfeited shall be used in a manner that is permitted within the applicable Department of Labor or Internal Revenue Service regulations and applicable state law. The maximum annual reimbursement under the Health Care FSA and LPFSA for 2020 shall be $2,700. Benefits and contributions may only be used to pay or reimburse expenses incurred with respect to the same qualified benefit.

6.02 HSA Reimbursement and Requirements

Each Participant's HSA will be credited with amounts withheld from the Participant's Compensation as selected through the procedures in Article III and any Non-elective Contributions allocated thereto by the Employer. By electing to participate in this benefit, Participants agree to have their Compensation reduced to make the applicable Elective Contributions. The account will be debited for health care reimbursements disbursed to the Participant in accordance with this Article VI. Only the current balance of the HSA shall be available to the Participant, and the maximum annual reimbursement under the HSA for 2020 shall be $7,100 for family plan and $3,550 for a single plan, and any additional qualifying catch-up contributions or rollover contributions from an HSA. Amounts distributed from an HSA may be used to pay for Eligible Medical Expenses, premiums for federally-required continuation coverage, premiums for long-term care insurance as limited by the IRS, premiums for health coverage for a Spouse or Dependent while that Spouse or Dependent is receiving unemployment compensation, and Medicare Part D premiums if the Participant has attained age 65. Should Participant become ineligible to contribute to an HSA, Participant may prospectively revoke contributions to the HSA. Additionally, Participants may prospectively change contributions selected on a Salary Reduction Agreement on a monthly basis. The balance of the HSA is nonforfeitable.

Additional requirements regarding eligibility, contributions, transitions between Health Care FSA and HSA, and other restrictions may be found in the Component Plan.

6.03 HSA and LPFSA.

To enroll in an HSA and/or a LPFSA, a Participant must also be enrolled in a high deductible health plan (HDHP). A qualified expense under a LPFSA is limited to Limited Eligible Health Care Expenses, which covers dental, vision, and preventive services or supplies that are excluded from coverage under the HDHP. A qualified expense under an HSA is limited as stated in Section 6.02. Some dental and vision services may be considered medical in nature and are covered under the HDHP. A dental or vision service covered by the HDHP cannot be reimbursed under this LPFSA even if the cost for the service was credited towards the deductible. Expenses that have been reimbursed through the HSA cannot also be reimbursed through the LPFSA.

6.04 Services after the annual HDHP Deductible has been satisfied.

As the LPFSA is a combination FSA under Treasury Regulation Section 1.125-5 (m) (5), the LPFSA is limited to Limited Eligible Health Care Expenses until the deductible for the HDHP is met. After the annual HDHP deductible has been satisfied, qualified expenses that are not covered by the HDHP or under any other plan can be submitted to and reimbursed by the LPFSA. An Explanation of Benefits ("EOB") from the insurance carrier that administers the HDHP will be required to be submitted. The EOB needs to show the HDHP deductible has been satisfied and the portion of the expense that has been submitted for reimbursement under this Plan was not applied to the HDHP deductible.

6.05 Carryover, Run-Out, and Grace Periods for Health Care FSA and LPFSA

The Plan Administrator has established a Run-out Period following the end of the Plan Year where eligible expenses incurred during the Plan Year can be claimed up to 90 days after the Plan Year has ended. A Run-out Period immediately follows the end of a Plan Year during which a Participant may request reimbursement of expenses incurred for qualified benefits during the Plan Year. Benefits and contributions may only be used to pay or reimburse expenses incurred with respect to the same qualified benefit. Component Plans may contain additional information about Run-out Periods.

The Plan Administrator has also established a Carryover Provision. The allowed carryover maximum will be communicated in the enrollment materials provided to each Eligible Employee at open enrollment or when a new or existing Employee becomes eligible for enrollment in the Plan. The carryover maximum will be the lessor of the amount communicated in the enrollment materials or $500. The allowed carryover will be the lesser of the allowed carryover maximum or the unused benefit balance at the end of the Run-out Period. The amount carried over has no effect on the ability to elect the maximum salary reduction allowed under the Plan for the new Plan Year. If a Participant elects the maximum salary reduction allowed under the Plan then the amount carried over will be in addition to that election. The Carryover provision applies to Eligible Employees only for the Plan Year in which the funds are to be carried over into.

6.06 DCFSA Reimbursement and Run-Out Period.

Each Participant's DCFSA will be credited with amounts withheld from the Participant's Compensation as chosen under Article III procedures and any Non-elective Contributions

allocated thereto by the Employer. Elections to the DCFSA cannot exceed $5,000 or $2,500 if a separate tax return is filed by a married Participant. By electing to participate in this benefit, Participants agree to have their Compensation reduced to make the applicable Elective Contributions. The purpose of the account is to cover Eligible Employment-Related Expenses. The account will be debited for dependent care reimbursements disbursed to the Participant in accordance with this Article VI. In the event that the amount in the account is less than that amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the DCFSA balance becomes adequate. In no event will the amount of dependent care reimbursements exceed the amount credited to the DCFSA. Any amount allocated to the DCFSA shall be forfeited by the Participant and restored to the Department if it has not been applied to provide dependent care reimbursement for the Plan Year within the Run-Out Period set forth below. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law.

The Plan Administrator has established a Run-out Period following the end of the Plan Year where eligible expenses incurred during the Plan Year can be claimed up to 90 days after the Plan Year has ended. All amounts allocated to the DCFSA that are not used to reimburse Eligible Employment Related Expenses incurred during the Plan Year shall be forfeited.

Benefits and contributions may only be used to pay or reimburse expenses incurred with respect to the same qualified benefit.

6.07 Receiving Reimbursement.

Payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or Participant's Dependents or for Eligible Employment-Related Expenses incurred by the Participant during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 6.08 herein are satisfied. If applicable, however, the Employer may offer to have the Participant choose to make payment for Eligible Medical Expenses with an electronic payment card arrangement, as described in Sec. 6.15 below.

6.08 Substantiation of Expenses.

Each Participant must submit an expense for reimbursement in accordance with the terms of the Component Plans and provide the required substantiation set forth in the Component Plans or as otherwise requested by the Plan Administrator or the TPA.

6.09 Repayment of Excess Reimbursements.

If, as of the end of the Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses or Eligible Employment-Related Expenses that have been substantiated by such Participant during the Plan Year, as required by Section 6.08 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

6.10 Reimbursement Following Cessation of Participation.

Participants in the Health Care FSA and LPFSA may submit claims for reimbursement for Eligible Medical Expenses incurred during the Plan Year and before the date of participation in the Plan ceases so long as the claim is submitted prior to the end of the Run-out period stated in Section 6.05. Unless a continuation coverage election is made under COBRA, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Participants in the DCFSA may submit claims for reimbursement for Eligible Employment-Related Expenses incurred during the Plan Year so long as the claim is submitted prior to the end of the Run-out period stated in Section 6.05. Any unused reimbursement benefits at the expiration of the Plan Year for the Health Care FSA, LPFSA or DCFSA shall be treated in accordance with Section 6.05 and 6.06. Participants in the HSA retain ownership of the funds within the HSA after participation in the Plan ceases. Participants should contact the TPA regarding treatment of the HSA funds prior to the date their participation in the Plan ceases.

6.11 Coordination of Benefits Under the Health Care FSA.

The Health Care FSA, HSA, and LPFSA are intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, they shall not be considered a group health plan for coordination of benefits purposes, and their benefits shall not be taken into account when determining benefits payable under any other plan.

6.12 Disbursement Reports.

The Plan Administrator shall issue directions to the Employer concerning all benefits that are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

6.13 Timing of Reimbursements.

Reimbursements shall be made as soon as administratively feasible after the Plan Administrator or its designee has received the required forms.

6.14 Statements.

The Plan Administrator or TPA may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing reimbursements under the Health Care FSA, HSA, LPFSA and/or DCFSA.

6.15 Use of Payment Cards

The Plan Administrator may elect at any time to provide a Participant in the LPFSA, HSA, or Health Care FSA with a payment card to be used for payment of Eligible Employment-Related Expenses or Eligible Medical Expenses and other expenses allowed by federal law, provided that each Participant certifies upon enrollment and each Plan Year thereafter that the payment card will be used only for eligible expenses up to the amount of the applicable limitations for the Plan Year and subject to such other conditions and requirements determined by the Administrator. If payment cards are issued, all charges to the card (except for those that can be substantiated at the point of sale) are treated as conditional pending confirmation of the expense. When the card is used, the merchant or service provider is paid the full amount of the charge and the debit is recorded in the applicable account, assuming sufficient coverage is available. Health Care FSA, LPFSA, and HSA debit cards can only be used at medical care providers, drugstores and

pharmacies, and other stores that meet IRS requirements regarding Health Care FSA debit card use.

ARTICLE VII: EMPLOYEE LIFE INSURANCE PLAN

7.01 Life Insurance Coverage Election.

Employees may elect, in accordance with the procedures of the Component Plan, to participate in Employee group life insurance coverage for a Plan Year or to waive such coverage.

7.02 Pretax Payment Feature.

For Employees who elected Employee life insurance coverage under the Component Plan, they may choose to become Participants under the processes of Article III, to have their premiums for Employee life insurance taken Pretax out of their compensation. By making this choice, Participants agree to have their Compensation reduced to make these Elective Contributions. Employers shall reduce the Participant's Compensation over the applicable Plan Year in an amount equal to the Participant's share of the cost of premiums for the elected health plan. It is the intention that the Employee group life insurance coverage provided under the Component Plan will be eligible for exclusion from the gross income of Participants under Code section 79 (a) in an amount that is less than or equal to the $50,000 limit provided in the Code. Coverage for Employees under the life insurance plan that exceeds the limit will not be excluded from gross income.

7.03 Life Insurance Plan Benefits and Terms.

The benefits available under and the governing terms of the Employee group life insurance plan shall be as set forth in the Component Plan. The Component Plan may contain requirements regarding eligibility and participation, and other terms, conditions, and limitations of coverage and benefits. To the extent there is conflict between the terms of this Plan and the life insurance plan, the terms of the life insurance plan shall govern, unless otherwise required to comply with the law. All requests for payment or benefits and appeals of denied claims under the group life insurance plan are subject to the claim and review procedures set forth the in corresponding Component Plan.

7.04 Life Insurance Coverage Upon Termination.

For purposes of Employee life insurance coverage, Sections 2.03 and 3.05 of this Plan do not apply. A Participant may continue group life insurance after terminating employment, if Participant meets the requirements stated in the Component Plan.

7.05 Additional Limitations.

The life insurance coverage offered in connection with this Plan includes only Employee group life insurance. Additional coverage may be offered for Spouses or Dependents under the Component Plan, but no additional coverage is intended to be offered in connection with this Plan. The life insurance coverage offered in connection with this Plan is not a permanent benefit as defined in 26 CFR 1.79-0.

ARTICLE VIII: PLAN ADMINISTRATION

8.01 Allocation of Authority.

The Board appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he or she may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he or she shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer, insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan; and

(f) To do all things necessary to operate and administer the Plan in accordance with its provisions.

8.02 Provision for Third Party Administrators.

The Plan Administrator, subject to approval of the Board, may employ the services of such persons, known as a TPA, as it may deem necessary or desirable in connection with the operation of the Plan and may rely upon all tables, valuations, certificates, reports and opinions furnished thereby. The TPA shall also perform required discrimination testing on behalf of the Plan Administrator. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Department.

8.03 Fiduciary Liability.

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Plan.

8.04 Compensation of Plan Administrator.

Unless otherwise determined by the Board and permitted by law, any Plan Administrator who is also an Employee of the State shall serve without compensation for services rendered in such capacity, but the State shall pay all reasonable expenses incurred in the performance of their duties.

8.05 Payment of Administrative Expenses.

The Employer currently pays all reasonable expenses incurred in administering the Plan.

8.06 Funding Policy.

The Board shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefit Plan Options offered under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Board to reduce premium payments or establish reserves, as described in Wis. Stat. 40.03 (6) (e). Except as provided in the Component Plans, the Employer is not liable for any obligations accruing from the operation of the Benefit Plan Options.

ARTICLE IX: FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to Salary Reduction Agreements or Election Forms, and/or Non-elective Contributions provided by the Employer, as determined by DPM or another appropriate authority provided in the Wisconsin statutes. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations.

ARTICLE X: CLAIMS PROCEDURES

10.01 Notice.

The Plan has established procedures for reviewing claims; these procedures apply only to Benefit Plan Options offered under this Plan. All requests for payments or benefits and appeals of denied claims under a Benefit Plan Option are subject to the claim and review procedures set forth in the Component Plan governing documents.

10.02 General Procedures.

(a) Upon receipt of a notice of denial from the TPA, a written appeal may be filed within ninety (90) days of the date of receipt of the notice. The written appeal should be sent directly to the TPA at the address indicated in the SPD.

(b) If the claim is again denied by the TPA, a participant may appeal the decision to the Department for either an informal review or a departmental determination within sixty (60) days of the receipt of the notice of the second denial. For an informal review, the Department will respond within sixty (60) days. For a departmental determination, the Department will attempt to send that determination to the participant within ninety (90) days of the request.

(c) Departmental determinations may be appealed to the Board within ninety (90) days of the Department's decision. Board appeals are conducted in accordance with Wisconsin Administrative Code Chapter ETF 11.

(d) As provided in Wis. Stat. 40.08 (12), decisions of the Board may be reviewed by an action filed in the circuit court for Dane County, within 30 days after the notice of the Board's decision is mailed. In some circumstances, as described in the notes to Wis. Stat. 40.08 (12), an appeal may be filed directly to the circuit court without following the above procedures.

10.03 Denials.

If a claim is denied, in whole or in part, the denial notice will provide the following information: (i) the specific reasons for the denial, (ii) references to pertinent plan provisions upon which the decision is based, (iii) a description of any additional material or needed, along with an explanation of why such material or information is needed, (iv) the claimant's right to request a review of the denial under the Plan's review procedures and a description of those procedures, including applicable time limits, and (v) a statement of the next steps required in the appeals procedure.

ARTICLE XI: AMENDMENT OR TERMINATION OF PLAN

11.01 Permanency.

While the Board fully expects that this Plan will continue indefinitely, due to unforeseen future business contingencies, permanency of the Plan will be subject to the Board's right to amend or terminate the Plan, as provided in Sections 11.02 and 11.03, below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

11.02 Board's Right to Amend.

The Board reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Board in accordance with its normal procedures for transacting business (as stated in the Board's governance manual). Such amendments will apply prospectively as set forth in the amendment and required by the Code. Each Benefit Plan Option shall be amended in accordance with the terms specified in its Component Plan, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Board shall be deemed approved and adopted by all Employers.

11.03 Board's Right to Terminate.

The Board reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Board in accordance with its normal procedures for transacting business. Employers may withdraw from participation in the Plan, but may not terminate the Plan. However, no such termination will modify a Participant's or other beneficiary's rights with respect to Plan benefits to which they have become entitled. Upon termination of the Plan, all elections and Compensation reductions under the Plan will cease. Any reduction in a Participant's Compensation made prior to termination of the Plan for an Elective Contribution amount that relates to a period after the termination of the Plan will be paid to the Participant and included in wages for the taxable year, unless the Plan Administrator determines, in its sole discretion, that Participants who are participating in a Pretax payment feature and continuing coverage under the underlying benefit plan shall have the opportunity to apply some or all of such amounts toward the premiums payable by the Participant for such ongoing coverage. In connection with a Plan termination, the Plan Administrator may (i) establish a grace period following the termination date during which Dependent Care Reimbursement Plan and/or Medical Expense Reimbursement Plan Participants may continue to incur reimbursable eligible expenses and/or (ii) shorten the run-out period in which a claim for reimbursement must be submitted; provided that, to the extent reasonably practicable, the run-out period shall end no earlier than the 30th day following the termination date

11.04 Component Plans.

Nothing in this Plan restricts the ability of the Board, or the Department if designated by the Board, to amend or terminate any of the Benefit Plan Options and their underlying Component Plans at any time in accordance with applicable law.

11.05 Determination of Effective Date of Amendment or Termination.
Any such amendment, discontinuance or termination shall be effective as of such date as the Board shall determine.

ARTICLE XII: GENERAL PROVISIONS

12.01 Limitation of Rights.

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer or any legal or equitable rights against the Employer or the Plan Administrator, except as provided herein.

12.02 Governing Laws.

The provisions of the Plan shall be construed, administered and enforced according to the governing federal law and the laws of Wisconsin, to the extent not preempted. Specifically, the Plan shall be construed, administered and enforced according to applicable sections of COBRA, HIPAA, the Code, Wis. Stats. Ch. 40, Wisconsin Administrative Code ETF 11, and other applicable laws.

12.03 Requirement for Proper Forms.

All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

12.04 No Guarantee of Tax Effects; Indemnification.

The Plan is designed and intended to operate as a "cafeteria plan" under Code § 125. Neither the Board, Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pretax Contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Board, Plan Administrator, or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. It is the Participant's obligation to notify the Plan Administrator if the Participant has any reason to believe that any amount intended to be excludable from gross income for federal income tax purposes may not be. If a Participant knowingly provides misinformation to the Plan Administrator, Employer, or Board that results in a disallowance of exclusion for a Pretax payment made on behalf of the Participant under the Plan, the Board has the right to seek indemnification and reimbursement from the Participant for any liability it may incur for failure to withhold federal, state, or local taxes that the Participant would have owed if such payment had been made to the Participant as regular cash compensation or failure to remit any employment taxes payable with respect to such amount.

12.05 Incorporation by Reference.

The actual terms and conditions of the separate component Benefit Plan Options offered under this Plan are contained in Component Plans that shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. In addition, the SPD for this Plan, as amended from time to time, is incorporated herein.

12.06 Severability.

Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

12.07 Effect of Mistake.

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

12.08 Treatment of Benefit Plan Options Upon Death or Inability to Locate Payee.

Any benefits payable under this Plan after the death of a Participant shall be paid to Participant's surviving Spouse or to Participant's estate. The Plan Administrator may retain amounts which are contested, until the rights in regard to the contested amount are settled, without liability for interest on the amounts. If the Plan Administrator is unable to make payment to a Participant or other person to whom a payment is due under the plan because the individual cannot be located or identified after reasonable efforts to do so, such payment and all subsequent payments shall be forfeited after a reasonable time. Component Plans may contain additional terms regarding the payment of benefits upon death or inability to locate payee.

ARTICLE XIII: CONTINUATION COVERAGE

To the extent required by COBRA, HIPAA, or other law, Participants and their Spouses and Dependents whose coverage terminates under a Component Plan that is a group health plan because of a COBRA or HIPAA qualifying event will be given the opportunity to continue the same coverage that was in effect on the day before the qualifying event for the period prescribed by law, subject to all conditions and limitations prescribed by law. Individual Component Plans may contain additional opportunities to continue coverage. Participants will be notified of their eligibility for continuation coverage upon the occurrence of a qualifying event.

ARTICLE XIV: NONDISCRIMINATION

14.01 Cafeteria Plan Nondiscrimination Compliance

The Plan will not discriminate in favor of Highly Compensated Employees (within the meaning of Code section 125 (e)) as to benefits provided or eligibility to participate. The nondiscrimination requirements of Code sections 125 (b), 79 (d), 105 (h), and 129 (d) shall be followed with regards to Highly Compensated Employees and Key Employees under the applicable Benefit Plan Option.

14.02 Corrective Action

If the Plan Administrator determines before or during any Plan Year that the Plan may fail to satisfy for such Plan Year any applicable nondiscrimination requirement imposed under federal or state law or any applicable limitation on contributions or benefits, the Plan Administrator will take such action as it deems appropriate, consistent with IRS guidance, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, modification of Participant benefit or contribution elections; return of Elective Contributions to Participants, and/or inclusion in a Participant's gross income of benefits intended to be excludable under a Component Plan with respect to Participants who are Highly Compensated Individuals or Key Employees. Affected Participants will be notified in advance of such actions.

IN WITNESS WHEREOF, the Employer has executed this Cafeteria Plan as of the date set forth below.

State of Wisconsin Department of Employee Trust Funds
Authorized Board: State of Wisconsin Group Insurance Board
By *(Name)*: Herschel Day, Chair, Group Insurance Board
Signature:
Date of Signature:
Contact A. John Voelker, ETF Deputy Secretary, if questions arise: (608) 266-9854

APPENDIX 1 – CAFETERIA PLAN LIFE EVENT MATRIX

Section 125 Cafeteria Plan Rules for Mid-Year Employee Election Changes							
The purpose of this chart is to identify examples of employee, spouse, or dependent life events that **may** create a permitted election change event. Election change requests must generally be made within 30 days of the event. The changes allowed must relate to the life event; e.g. if a child ages out, you may remove that child from the plan, but would not be allowed to remove other dependent children from the plan. Documentation regarding the qualifying life event may be required; after submitting the change of election form, you will be contacted to request documentation if it is needed. Most changes will be effective as of the first of the month following the election change request. If cancelling coverage under one or more of the plans, cancellation will be effective the end of the month. Information regarding effective date will be provided upon submission of the change of election. If you are eligible for a COBRA event, you may increase your contribution to cover the COBRA premium rate. The individual Component Plans may have additional life event requirements, as provided under the terms of those plans, and the terms of this matrix are not intended to override any of those requirements.							
Special Rules for HSA's	If you have an HSA, the law permits you to change your elections monthly, on a prospective basis. If you are newly enrolling in a High Deductible Health Plan, you are required to enroll in an HSA, but may have a $0 contribution to the HSA. Adding a dependent allows an increase in contributions. Should you become ineligible to make HSA contributions, you will be allowed to prospectively revoke your salary reduction election for HSA contributions.						
Life Event	Permitted Changes						
	Medical	Dental	Vision	Life	HCFSA	LPFSA	DCFSA
Change in Marital Status: Marriage	• Enroll • Change single to family • Add dependent(s) • Change health plan • Cancel coverage if you enroll in your spouse's plan	• Enroll • Add dependent(s) • Change single to family • Can change plans, but deductible will start over • Cancel coverage	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	• Enroll • Increase coverage • Change beneficiaries • Cancel coverage • Purchase non-Sec. 125 coverage for spouse and dependents	• Enroll or increase election if adding dependent(s) • Cancel or decrease election if you enroll in your spouse's plan	• Enroll or increase election if adding dependent(s) • Cancel or decrease election if you enroll in your spouse's plan	• Enroll or increase election if adding eligible dependent(s) • Cancel or decrease if spouse has election with his/her employer or will be taking over care duties
Change in Marital Status: Divorce, Annulment	• Enroll if lost coverage as a dependent of your former spouse • Change family to single • Change health plan • Drop dependent	• Enroll if lost coverage • Cancel former spouse's coverage Cancel dependent children coverage if	• Enroll if lost coverage • Cancel former spouse's coverage Cancel dependent children coverage if	May cancel all or certain levels of coverage at any time	• Enroll or increase election • Cancel or decrease election	• Enroll or increase election • Cancel or decrease election	• Enroll or increase election if expenses increase due to separation • Cancel or decrease if separation

	• Cancel coverage if you enroll in another plan	will enroll through former spouse • Former spouse eligible for COBRA	will enroll through former spouse • Former spouse eligible for COBRA				eliminates need for care
Life Event	Medical	Dental	Vision	Life	HCFSA	LPFSA	DCFSA
Change in Marital Status, Death of Spouse	• Enroll if lost coverage as a dependent of your former spouse • Change family to single • Drop dependent • Cancel coverage if you enroll in another plan	• Enroll if lost coverage • Cancel former spouse's coverage Cancel dependent children coverage if will enroll through former spouse • Former spouse eligible for COBRA	• Enroll if lost coverage • Cancel former spouse's coverage Cancel dependent children coverage if will enroll through former spouse • Former spouse eligible for COBRA	May cancel all or certain levels of coverage at any time	• Enroll or increase election • Cancel or decrease election	• Enroll or increase election • Cancel or decrease election	• Enroll or increase election if expenses increase due to separation • Cancel or decrease if separation eliminates need for care
Add Dependent: Birth, Adoption, Placement for Adoption, Proof of Paternity or Maternity	• Enroll • Change single to family • Add dependent(s) • Change health plan • Cancel coverage if you enroll in another plan	• Enroll • Add dependent(s) • Change single to family • Can change plans, but deductible will start over • Cancel coverage	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	• Enroll • Increase coverage • Change beneficiaries • Cancel coverage • Purchase non-Sec. 125 coverage for spouse and dependents	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election
Add Dependent: Court Order, National Medical Support Notice	• Enroll • Change single to family • Add dependent(s) • Change health plan • Cancel coverage if you enroll in another plan	• Enroll • Add dependent(s) • Change single to family • Can change plans, but deductible will start over • Cancel coverage	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	May cancel all or certain levels of enrollment at any time	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election

Life Event	Medical	Dental	Vision	Life	HCFSA	LPFSA	DCFSA
Add Dependent: Legal Guardianship	• Enroll • Change single to family • Add dependent(s) • Cancel coverage if you enroll in another plan	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	• Enroll • Increase coverage • Change beneficiaries • Cancel coverage • Purchase non-Sec. 125 coverage for spouse and dependents	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election
Add Dependent: Transfer of Custody	• Enroll • Change single to family • Add dependent(s) • Cancel coverage if you enroll in another plan	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	• Enroll • Add dependent(s) • Change single to family • Cancel coverage	• Enroll • Increase coverage • Change beneficiaries • Cancel coverage • Purchase non-Sec. 125 coverage for spouse and dependents	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election • Cancel or decrease election if you enroll in another plan	• Enroll or increase election
Add Dependent: Unmarried 26+ becomes Disabled	• Add dependent • Change single to family	• Add dependent • Change single to family	• Add dependent • Change single to family	May cancel all or certain levels of coverage at any time	• Enroll or increase election	• Enroll or increase election	• Enroll or increase election
Add Dependent: Other	Check with HR. Generally, enrollment and change single to family allowed. Other changes may be allowed.	Check with HR. Generally, enrollment and change single to family allowed. Other changes may be allowed.	Check with HR. Generally, enrollment and change single to family allowed. Other changes may be allowed.	Check with HR. Enrollment or an increase in coverage may be allowed. May cancel all or certain levels of	Check with HR. Generally, enroll or increase election allowed. Other changes may be allowed.	Check with HR. Generally, enroll or increase election allowed. Other changes may be allowed.	Check with HR. Generally, enroll or increase election allowed. Other changes may be allowed.

				coverage at any time.			
Life Event	Medical	Dental	Vision	Life	HCFSA	LPFSA	DCFSA
Remove Dependent: Aged Out, Death	• Must remove dependent • Change family to single if no other dependents	• Must remove dependent • Change family to single if no other dependents	• Must remove dependent • Change family to single if no other dependents	May cancel all or certain levels of coverage at any time	• Cancel or decrease election	• Cancel or decrease election	• Cancel or decrease election
Remove Dependent: Other (e.g. dependent age 19+ gains other coverage, etc.)	Check with HR. Varies based on exact situation.	Check with HR. Varies based on exact situation.	Check with HR. Varies based on exact situation.	May cancel all or certain levels of coverage at any time	Check with HR. Generally, cancel or decrease election. Varies based on exact situation.	Check with HR. Generally, cancel or decrease election. Varies based on exact situation.	Check with HR. Generally, cancel or decrease election. Varies based on exact situation.
Death of Employee	Notify HR and ETF. Insured spouse/dependents eligible to continue coverage per WIs Adm Code ETF 40.01.	Notify vendor. Spouse/dependents eligible for COBRA.	Notify vendor. Spouse/dependents eligible for COBRA.	Notify Securian. Complete form ET-6301, attaching obituary and death certificate, if available.	Notify vendor. Spouse/dependents may be eligible for COBRA.	Notify vendor. Spouse/dependents may be eligible for COBRA.	Continues through end of the current plan year, till Dec. 31.
Move from health plan's service area for at least 3 months	May choose a new health plan that includes new address in its service area.	No changes.	No changes.	May cancel all or certain levels of coverage at any time	No changes.	No changes.	If move affects expenses, may: • Enroll or increase • Cancel or decrease
Change in Employment Status: Hiring, employee meets requirements for greater share of employer	• Enroll • Change single to family or family to single • Change health plan • Cancel coverage if you enroll in another plan	• Enroll • some restrictions based on type of employee	• Enroll • some restrictions based on type of employee	• Enroll • Waive	• Enroll • Waive • some restrictions based on type of employee	• Enroll • Waive • some restrictions based on type of employee	• Enroll • Waive • some restrictions based on type of employee

contribution toward coverage	• Some restrictions based on type of employee						
Life Event	Medical	Dental	Vision	Life	HCFSA	LPFSA	DCFSA
Change in Employment Status: State Agency Transfer	Talk to HR. Need transfer application if new agency uses different payroll system.	No Change	No Change	Talk to HR. Need transfer application if new agency uses different payroll system.	Complete a transfer form from previous payroll system	Complete a transfer form from previous payroll system	Complete a transfer form from previous payroll system
Change in Employment Status: Re-hiring within 30 days	Prior elections will be reinstated.	Prior elections will be reinstated.	Prior elections will be reinstated.	Prior elections will be reinstated.	Prior elections will be reinstated.	Prior elections will be reinstated.	Prior elections will be reinstated.
Change in Employment Status: Termination or Permanent Layoff	Eligible for COBRA.	Eligible for COBRA.	Eligible for COBRA.	Vendor may offer opportunities to continue coverage. May cancel all or certain levels of coverage at any time.	May be eligible for COBRA.	May be eligible for COBRA.	Continues through end of the current plan year, till Dec. 31.
Change in Employment Status: Retirement	• Enroll in Access Plan 30 days prior to retirement if employer offers employee sick leave conversion credits to pay for health insurance in retirement • Coverage automatically continues	• COBRA continuation • Continue coverage as a retiree • Change family to single	• COBRA continuation • Continue coverage as a retiree • Change family to single	May cancel all or certain levels of coverage at any time	• Upon retirement, HCFSA terminates. • Not eligible for COBRA Continuation Payment.	• Upon retirement, HCFSA terminates. • Not eligible for COBRA Continuation Payment.	Continues through end of the current plan year, till Dec. 31.

	• Change coverage family to single or single to family • Cancel						
Life Event	Medical	Dental	Vision	Life	HCFSA	LPFSA	DCFSA
Change in Employment Status: Disability	No change	No change	No change	May cancel all or certain levels of coverage at any time	No change	No change	No change
Change in Employment Status: Significant reduction in Employer Contribution	• Change family to single • Cancel coverage, if you enroll in another plan	• Cancel	• Cancel	May cancel all or certain levels of coverage at any time	No change	No change	No change
Change in Employment Status: Leave of Absence or Temporary Layoff	• Change family to single • Cancel (coverage will lapse with non-payment of premium)	• Change family to single • Cancel	• Change family to single • Cancel	May cancel all or certain levels of coverage at any time	Cancel or decrease election prior to LOA.	Cancel or decrease election prior to LOA.	Cancel or decrease election prior to LOA.

Cafeteria Plan Document Requirements Checklist		
A "No" answer may result in the plan failing a requirement with the Internal Revenue Code. Check with OLS if you answer no to any of the requirements.		
	Does the cafeteria plan document meet all of the following?	**Where? As of 5/23/2019**
□ Yes □ No	Was the plan adopted and effective on or prior to the first day of the plan year to which it relates?	Page 1, Preamble
□ Yes □ No	Do the terms of the plan apply uniformly to all participants?	Not directly stated in the Plan Document, but does apply uniformly and can be implied from language in the Plan Document.
□ Yes □ No	Does the plan provide a specific description of each of the benefits available through the plan, including the period during which the benefits are provided?	Preamble, Articles V, VI, VII; period of benefits is mentioned throughout, such as in 1.35.
□ Yes □ No □ Yes □ No	Are there rules governing participation and eligibility, and specifically is there a requirement that all participants in the plan must be employees?	Article III, 1.17 Preamble
□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No	Are there procedures governing employee' elections under the plan? • Do they include the period when elections may be made? • Do they include the periods with respect to when elections are effective? • Do they provide that elections are irrevocable, except to the extent a change in status event applies?	Article III 3.02 3.02 and 2.02 3.04
□ Yes □ No □ Yes □ No	Does the plan contain procedures governing changes in elections, such as allowed change in status events? Are such changes only allowed on a prospective basis?	3.04 3.04
□ Yes □ No	Does the plan detail the manner in which employer contributions may be made under the plan (e.g. salary reduction or non-elective contribution)?	4.01
□ Yes □ No □ option 1 □ option 2	Does the plan include the maximum amount of elective contributions available to any employee through the plan? Is it expressed as a maximum dollar amount, a	4.01

□ option 3	maximum percentage of compensation, or the method for determining the maximum dollar amount?	
□ Yes □ No	Does the plan clearly state the plan year?	1.35
□ Yes □ No	Does the plan state that benefits or contributions relating to a particular qualified benefit may only be used to pay or reimburse expenses incurred with respect to the same qualified benefit?	Throughout Article VI
□ Yes □ No □ Yes □ No □ Yes □ No	Are any amendments to the plan in writing? Are the amendments only effective for periods after the later of the adoption date or effective date of the amendment? If an amendment adds a new benefit, does the plan only pay or reimburse those expenses for the new benefit incurred after the later of the amendment's adoption date or effective date?	N/A- do not need to be stated in the Plan Document, just need to be followed
□ Yes □ No	Does the plan state that no contribution or benefit from a health FSA in excess of $500 may be carried over to any subsequent plan year?	6.05
□ Yes □ No	Does the plan provided that the maximum amount of reimbursement from a health FSA is available for payment at least monthly during the period of coverage?	6.01
□ Yes □ No	Does the plan stipulate the length of any run-out period? (i.e. period by which claims must be submitted after the plan year in order to be reimbursed)	6.05 and 6.06
□ Yes □ No	Does the plan stipulate the period of time after an employee ceases to be a participant when claims for reimbursement may be submitted by the former participant?	6.10
□ Yes □ No	Does the plan define what is meant by expenses that are "incurred"?	Multiple places throughout the Plan Document (e.g. 1.19)
□ Yes □ No	Does the plan perform all required discrimination testing?	N/A- doesn't need to be in Plan Document, just followed
□ Yes, it does not include	The plan does not include benefits not allowed to be offered in a cafeteria plan, such as:	N/A

□ No, it includes: _____ _____	• Spouse and dependent life insurance coverage; • Transportation fringe benefits; • Long term care insurance; • Pension and retirement benefits; • Benefits that operate through a deferral of compensation; • Tuition reduction and educational assistance	
□ Yes □ No	Do the HCFSA and LPFSA comply with the current IRS limits on contributions? (May not exceed, but may have a lower limit)	6.01
□ Yes □ No	Does the DCFSA comply with the current IRS limit on contributions? (May not exceed, but may have a lower limit)	6.06
□ Yes □ No	Does the HSA comply with the current IRS limit on contributions? (May not exceed, but may have a lower limit)	6.02