Plan Document

City of Norman, Oklahoma

Flexible Spending Plan

City of Norman, Oklahoma
Flexible Spending Plan
(Premium/Health/Dependent Care)
Amended December 13, 2022

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RECITALS

WHEREAS, the Employer desires to sponsor a salary reduction flexible spending plan ("Plan") pursuant to Section 125 of the Internal Revenue Code of 1986, as amended ("Code"), for the benefit of certain of its employees; and

WHEREAS, the Employer desires to adopt the Plan on the Effective Date as specified in the Adoption Agreement.

NOW, THEREFORE, the Employer does hereby agree as follows:

ARTICLE I

DEFINITIONS

When used herein, the following words and phrases shall have the following meanings, unless the context clearly indicates otherwise.

1.1 **Annual Enrollment Election Period** means the period of time (to be announced each year by the Plan Administrator) each Plan Year during which an Eligible Employee makes (or is deemed to make) his or her contribution elections for the upcoming Plan Year.

1.2 **Benefit** means any of the benefits to which a Participant is entitled to under the Plan.

1.3 **Code** means the Internal Revenue Code of 1986, as amended.

1.4 **Compensation** means the total of all amounts paid to or accrued to the Eligible Employee as salary and wages for services rendered and labor performed for the Employer during the Plan Year including Employee contributions to the Plan and salary reductions under any other Employer benefit plan.

1.5 **Dependent** means an individual who qualifies as a dependent under the provisions of Section 152 of the Code.

1.6 **Dependent Care Expense Reimbursement Account** means the individual dependent care account established by the Employer for each participant for the purpose of accounting for contributions thereto and Benefits paid therefrom for eligible dependent care expenses.

1.7 **Dependent Care Reimbursement Plan** means the Employer-Sponsored Dependent Care Reimbursement Plan as attached hereto as Exhibit "A", together with any and all amendments or supplements thereto.

1.8 **Effective Date** means the first day of the Plan Year as specified in the Adoption Agreement in which the Plan is adopted or in which a plan previously maintained by the Employer is amended and restated in the form of the Plan

1.9 **Eligible Employee** means any Employee of the Employer who is eligible to participate in the Plan as specified in the Adoption Agreement.

1.10 **Employee** means any person employed by the Employer or a former Participant with accrued Salary Reduction at the time of termination as

provided herein (Note: partners of a partnership, sole proprietor of an unincorporated sole proprietorship or 2% shareholders of an S corporation are not considered employees for the purposes of the Plan).

1.11 **Employer** means the Employer as specified in the Adoption Agreement, or any successor(s) thereto, whether by merger, consolidation or otherwise. In addition, any other entity which adopts the Plan with the written consent of the Employer shall be deemed an Employer of the Plan.

1.12 **Employer-sponsored Health Care Plan** means the core Employer-sponsored health care plan as specified in the Adoption agreement, and as may be amended and substituted from time to time, the premium costs of which may be paid through the Pre-tax Premium Account.

1.13 **Employer-sponsored Plans** means the Employer-sponsored plans as specified in the Adoption Agreement and as may be amended and substituted from time to time, the Premium costs of which may be paid through the Pre-tax Premium Account.

1.14 **ERISA** means the Employer Retirement Income Security Act of 1974, as amended.

1.15 **Flexible Spending Plan** (See 1.19 Plan.)

1.16 **Full-Time Student** means an individual who during each of at least five (5) months during the Participant's taxable year is enrolled at an educational organization described in Section 170(b)(1)(A)(ii) of the Code. The individual must enroll for the number of course hours considered to constitute full-time study, and may not attend exclusively at night.

1.17 **Health Care Expense Reimbursement Account** means the individual health care account established by the Employer for each Participant for the purpose of accounting for contributions thereto and Benefits paid therefrom for eligible health care expenses.

1.18 **Participant** means any Eligible Employee who actually enrolls or who is deemed to enroll, and participates in the Plan.

1.19 **Plan** means the Employer-sponsored Flexible Spending Plan, together with any and all amendments and supplements thereto.

1.20 **Plan Administrator** means the person, firm or entity appointed by the Employer to manage and direct the operation of the Plan. If no such person, firm or entity is named, the Plan Administrator shall be the Employer.

1.21 **Plan Year** means the annual accounting period of the Plan, which shall begin and end on the dates as specified in the Adoption Agreement in that same year.

1.22 **Pre-tax Premium Account** means the individual premium account established by the Employer for each Participant for the purpose of accounting for contributions thereto and Benefits paid therefrom for Employer-sponsored Plans premiums.

1.23 **Premiums** means the Employee's costs for elected participation in the Employer-sponsored Plans, as may be offered from time to time by the Employer.

1.24 **Qualified Benefit** means any benefit excluded from taxation under Chapter 1 of the Code (other than Section 117, 127 or 132), including (a) any group- term life insurance coverage that is includible in gross income only by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79; and (b) any other benefit permitted by the Income Tax Regulations.

1.25 **Salary Redirection** means the amount by which an Employee elects to have his Compensation reduced in an amount sufficient to fund the Benefits such Employee has elected to receive under the Plan, subject to the terms, conditions and restrictions provided in the Plan.

1.26 **Salary Redirection Agreement** means a written agreement by and between the Eligible Employee and the Employer entered into during the applicable Annual Enrollment Election Period whereby the Eligible Employee agrees to a reduction in Compensation for the purpose of purchasing Benefits and which for all purposes hereunder are deemed to be Employer contributions.

1.27 **Termination of Participation** means the termination of a Participant's eligibility under the Plan because of termination of employment as an Employee of the Employer, whether by reason of a reduction in hours, discharge, layoff, voluntary termination, involuntary termination, disability, retirement, death or otherwise.

ARTICLE II

PURPOSE AND EFFECTIVE DATE OF THE PLAN

2.1 **Purpose**. The Plan is a welfare benefit plan under ERISA, and is intended to qualify as a nondiscriminatory salary reduction cafeteria plan under Sections 129, 125, 106, 105 and 79 of the Code. The Plan allows employees the flexibility of choosing between certain Qualified Benefits through the Plan's Salary Redirection option or cash compensation. The Plan is further intended as an accident and health plan within the meaning of Section 105(e) of the Code and that reimbursements paid through the Health Care Expense Reimbursement Account be eligible for exclusion from Participant's income under Section 1OS(b) of the Code. Accordingly, the Plan shall be interpreted and construed in accordance with all such Sections of the Code and the regulations issued thereunder.

2.2 **Separate Plan Documents**. The Benefits offered under the Plan may be the subject of separate plan documents, agreements, policies and contracts and are incorporated herein by reference as the same may be changed from time to time.

In the event of a conflict between the terms of the Plan and the terms of another plan contract or a particular insurer whose product is then being used in conjunction with the Plan, the terms of the other plan shall control as to those Participants receiving coverage under such other plan. For this purpose, the other plan shall control in defining the persons eligible for

coverage, the dates of their eligibility, the conditions which must be satisfied to become covered, if any, the benefits the Participants are entitled to and the circumstances under which coverage terminates.

2.3 **Name**. The Plan shall be referred to as specified in the Adoption Agreement.

2.4 **Effective Date**. The Effective Date of the Plan (and amendment thereto) is as specified in the Adoption Agreement.

ARTICLE 111

ELIGIBILITY FOR PARTICIPATION

3.1 **Eligible Employee**. All Eligible Employees as specified in the Adoption Agreement are eligible to participate in the Plan.

3.2 **Eligibility Begins**.

(a) **Initial Enrollment** - Eligibility begins as specified in the Adoption Agreement

(b) **New Employee** – Eligibility begins as specified in the Adoption Agreement.

3.3 **Rehired Employees**. Rehired employees are eligible as specified in the Adoption Agreement.

ARTICLE IV

SALARY REDIRECTIONS

4.1 **Salary Redirections**. Participation in the Plan occurs through Salary Redirections made pursuant to the election procedures of Article V hereof. The Salary Redirection shall be equal to the annual dollar amount of Premium for coverage under the Employer-sponsored Plans in which the Participant is enrolled during the Plan Year and the amount elected by the Participant to purchase Benefits under the Plan for the Plan Year.

4.2 **Pro Rata Deductions**. The elected amount shall be deducted from the Participant's Compensation on a pro rata basis during the Plan Year. If on any pay day, a Participant's paycheck is insufficient to pay his or her pro rata elected amount, he or she must pay the remaining pro rata amount with after-tax dollars to the Plan Administrator within ten (10) days from such pay day. The Plan Administrator may, in its discretion, fix a limit on the amount of Salary Redirection a Participant may elect for a Plan Year for the purpose of complying with the Code and regulations thereunder.

ARTICLE V

PARTICIPATION, ELECTION AND CONTRIBUTIONS

5.1 **Annual Enrollment Election Period**. Prior to the Effective Date and prior to the start of each Plan Year (dates to be announced by the Plan Administrator each

year), the Plan Administrator shall provide each Eligible Employee with the opportunity to become a Participant in the Plan for the upcoming Plan Year. An Eligible Employee may also decline to participate in the Pre-tax Premium Account at this time.

5.2 **New Eligible Employees**. If an Eligible Employee is hired after the Annual Enrollment Election Period has ended, such Eligible Employee may make an election/declination within thirty (30) days of his or her first day of employment.

5.3 **Participation and Elections**

(a) **Pre-tax Premium Account** – An eligible Employee's participation in the Pre-tax Premium Account is automatic provided such Eligible Employee has enrolled and is participating in any of the Employer-sponsored Plans. If an Eligible Employee does not want to be a Participant in this account, such Eligible Employee must notify the Plan Administrator in writing, stating that he or she does not want to participate in the Pre-tax Premium Account. The Eligible Employee may do so either at the time he or she enrolls in the Employer-sponsored Plan or during the Annual Enrollment Election Period prior to the beginning of each Plan Year.

(b) **Health Care Expense Reimbursement Account and/or Dependent Care Expense Reimbursement Account –** Each Eligible Employee must decide and elect before the start of each Plan Year, the amount of such Eligible Employee's Compensation that he or she wants to redirect and receive as Benefits. Separate elections must be made for the Health Care Expense Reimbursement Account and the Dependent Care Expense Reimbursement Account. An Eligible Employee can elect Salary Redirection contributions just to the Health Care Expense Reimbursement Account or just to the Dependent Care Expense Reimbursement Account, or the Eligible Employee can elect to contribute to both account or to neither account.

5.4 **Salary Redirection Agreement**. Each Eligible Employee must complete the Salary Redirection Agreement indicating how much he or she wishes to contribute to the Health Care Expense Reimbursement Account and/or the Dependent Care Reimbursement Account and authorizing salary reduction. The Salary Redirection Agreement must be completed and received by the Plan Administrator (or designee) by the last day of each Annual Enrollment Election Period in order that an Eligible Employee may be a Participant in the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account for the upcoming Plan Year. A new eligible Employee must enroll within thirty (30) days from his or her first day of employment.

5.5 **Acceptance of Elections**. A Salary Redirection Agreement filed by a Participant is subject to acceptance, modification or rejection by the Plan Administrator. The Plan Administrator may modify or reject a Participant's election in order to satisfy legal or Code requirements, or for other good cause. Rejection of an election for a Plan Year shall cause the Eligible Employee not to be a Participant in the Plan for that Plan Year, unless prior to the beginning of the Plan Year, the Plan Administrator, in its discretion, permits the Participant to file a new election.

5.6 **Payroll Deductions**. Payroll deductions for Participants who enroll in the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account during the Annual Enrollment Election Period will begin on the Participant's first payday coinciding with or next following the first day of the Plan Year. Payroll deductions for Participants who become eligible after the Annual

Enrollment Election Period who enroll in the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account will begin on the Participant's second pay day next following the date he or she enrolls. Payroll deductions for the Employer-sponsored Plans will automatically begin when the Eligible Employee has met the eligibility requirements and enrolls in the Employer-sponsored Plans unless the Eligible Employee has previously declined participation in the Pre-tax Premium Account.

5.7 **Failure to Complete the Salary Redirection Agreement**. If an Eligible Employee does not return a completed Salary Redirection Agreement for the Health Care Expense Reimbursement Account and/or Dependent Care Expense Reimbursement Account during the Annual Enrollment Election Period (or, if a new Eligible Employee, within thirty (30) days of his or her first day of employment), the Eligible Employee's election for the Plan Year shall be deemed to be zero and no amounts will be deducted from the Eligible Employee's pay during the Plan year to fund these accounts.

5.8 **Minimum and Maximum Salary Redirections**. A Participant's annual election to the Health Care Expense Reimbursement Account and/or the Dependent Care Expense Reimbursement Account can be in any whole dollar amount; however, a Participant must elect a minimum annual contribution as specified in the Adoption Agreement. (The minimum annual contribution is prorated for a new Eligible Employee from his or her date of enrollment to Plan Year end.) The maximum amount that a Participant may elect to each reimbursement account is:

(a) **Health Care Expense Reimbursement Account –** A Participant's maximum annual contribution as specified in the Adoption Agreement.

(b) **Dependent Care Expense Reimbursement Account –** A Participant's maximum annual contribution is as specified in the Adoption Agreement; however, (I) if the Participant files a federal income tax return as "married, filing separately," such Participant's maximum annual contribution is $2,500; or (ii) if the Participant's annual earned income or the Participant's spouse's annual earned income is less than $5,000, the lowest income amount is the most such Participant can contribute.

In determining the Participant's spouse's income:

(i) If the Participant's spouse is "Disabled" (not physically or mentally able to care for himself or herself) and the Participant has no other qualifying Dependents, such spouse will be considered to have earned $200 each month such spouse is Disabled.

(ii) If the Participant's spouse is Disabled and the participant has one or more qualifying Dependents other than such spouse, such spouse will be considered to have earned $400 each month such spouse is Disabled.

(iii) If the Participant's spouse is a Full-Time Student and the Participant has one qualifying Dependent, such spouse will be considered to have earned $200 each month such spouse is a Full-Time Student.

(iv) Participant's spouse is a Full-Time Student and the Participant has more than one qualifying Dependent, such spouse will be considered to have earned $400 each month such spouse is a Full-Time Student.

5.9 **Qualified Change in Family Status**. Once a Participant has made or is deemed to have made his or her election for the Plan Year; that election will stay in effect for the entire Plan Year. A participant can only change his or her election if he or she

has a qualified change in family status, but only if election changes are necessary or appropriate as a result of the event giving rise to the qualified change in family status. A qualified change in family status includes:

(a) Participant's marriage or divorce;
(b) Birth or adoption of Participant's child;
(c) Death of Participant's spouse or Dependent
(d) Participant's spouse's termination or commencement of employment;
(e) Participant's spouse switching from part-time to full-time employment status or from full-time to part-time status;
(f) Participant switching from an ineligible employment status to an eligible employment status or from an eligible employment status to an ineligible employment status;
(g) Unpaid leave of absence by Participant or Participant's spouse; or
(h) Significant change in health coverage attributable to Participant's spouse's employment; or
(i) Any other change in family status permitted under Section 125 of the Code and the regulations thereunder.

The change to a Participant's annual election must be consistent with his or her family status change. The Participant may not; however, reduce his or her annual election to an amount less than the dollar amount of any reimbursable expenses submitted and to be submitted for the portion of the Plan Year ending prior to the date of such Participant's change of election.

A Participant must make a new election within thirty (30) days of such Participant's qualified change in family status for it to be effective for the remainder of the Plan Year.

5.10 **Change in Cost of Employer-sponsored Plans**. If a Participant elects to make contributions to the Plan to be used for the payment of Premiums, the amount of such Participant's contribution will automatically be adjusted during a Plan Year to reflect any Premium change in the Employer-sponsored Plans.

In addition, if the coverage under a health plan is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such health plan and, in lieu thereof, elect to receive on a prospective basis coverage under another health plan with similar coverage. The amount of such Participant's contribution will automatically be adjusted during the Plan Year to the Premium cost of such other health plan.

5.11 **Nondiscriminatory Benefits**. The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or Benefits, and to comply in this respect with the requirements of the Code and the regulations issued thereunder. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such Participants and/or reduce such Plan contributions and/or Benefits under the Plan in a uniform and non-discretionary manner, all as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate. However, in

no event shall such actions by the Plan Administrator result in a refund of elective contributions not used during a Plan Year in which contributions would have otherwise been forfeited.

ARTICLE VI

BENEFITS

6.1 **Benefits Options**. The Plan provides that a Participant may set aside a portion of his or her Compensation to pay his or her share of the Premiums under the Employer-sponsored Plans, and, also to make contributions to the Health Care Expense Reimbursement Account and to the Dependent Care Expense Reimbursement Account maintained under the Dependent Care Reimbursement Plan.

6.2 **Pre-tax Premium Account**. The Pre-tax Premium Account provides payment of a Participant's portion of the Premium cost of the Employer-sponsored Plan.

6.3 **Health Care Expense Reimbursement Account**. The amount a Participant has elected on his or her Salary Redirection Agreement to be applied to his or her Health Care Expense Reimbursement Account will be used to reimburse such Participant for eligible medical expenses.

(a) Eligible Medical Expenses. Eligible medical expenses are those expenses which are otherwise deductible on a Participant's federal income tax return (without regard to the percentage of adjusted gross income limitation) under Section 213 of the Code. However, eligible medical expenses shall not include an expense incurred for a Participant's premium payments for other health plan coverage, including premiums paid for health coverage under a plan maintained by an employer of the Participant's spouse or Dependent.

(b) Limitations of Eligible Medical Expenses. There are a few limitations on eligible medical expenses:

(i) Expenses must be incurred by a Participant, a Participant's spouse or Dependent;

(ii) They must be expenses which are not paid or reimbursed through another benefit plan or from any other source;

(iii) Expenses must be incurred during the Plan Year for which a Participant's election is made (expenses are treated as having been incurred on the date the services are provided);

(iv) Expenses must be incurred while a Participant is participating in the Health Care Expense Reimbursement Account; and

(v) A Participant cannot deduct reimbursed expenses from his or her income taxes.

6.4 **Dependent Care Expense Reimbursement Account**. The amount a Participant elects to be applied to such Participant's Dependent Care Expense Reimbursement Account will be used to reimburse such Participant for eligible dependent care expenses subject to the terms and conditions as provided in the Dependent Care Reimbursement Plan.

6.5 **Cash**. In lieu of the Qualified Benefits herein provided, to the extent that a Participant waives Benefits thereunder, such Participant shall be deemed to have

elected to receive equivalent amounts as a taxable benefit in the form of cash compensation.

6.6 **Limitation of Benefits**. In no event shall the total Premiums or Benefits paid with respect to the Benefits selected by a Participant for any Plan Year exceed the amount by which such Participant elected or is deemed to have elected to reduce his or her cash Compensation in his or her Salary Redirection Agreement.

Each of the various Qualified Benefits which are or may be offered by the Employer under the Plan may have limitations, in addition to any limitations provided herein, and the separate limitations with respect to any particular Qualified Benefits shall govern where applicable.

6.7 **Statement of Benefits**. The Plan Administrator shall furnish to each Participant a copy of such Participant's Salary Redirection Agreement as a record of the Benefits to be provided such Participant during the Plan Year.

6.8 **Nature of Accounts**. No money shall actually be allocated to any account. Any such account shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be a representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to any account.

6.9 **Forfeitures**. Subject to Section 7.5 hereof, any account balance remaining in a Participant's Health Care Expense Reimbursement Account and/or Dependent Care Reimbursement Account at the end of the Plan Year will be forfeited. The Plan Administrator shall transfer to the Employer all funds held pursuant to the Plan that remain on hand as of the end of the Plan Year and such funds shall become the property of the Employer.

6.10 **Benefits Under Employer-sponsored Plans**. The Benefits provided in the Employer-sponsored Health Care Plan and Employer sponsored Plans are subject to the terms and conditions as provided in those plan documents and are not governed or provided under the Plan.

ARTICLE VII

REIMBURSEMENT PROCEDURES

7.1 **Request for Reimbursement**. When a Participant has at least the minimum reimbursement amount as specified in the Adoption Agreement of expenses during the Plan Year which are eligible for reimbursement, such Participant must complete an expense reimbursement request form and forward it as specified in the Adoption Agreement. A Participant will be required to provide information verifying to the Plan Administrator (or designee) that he or she has incurred the eligible expense, such as a statement or receipt. Distributions from a Participant's account to pay far an eligible health or dependent care expense will only be made for services that have already been performed, even though such Participant may have previously paid the provider for such services. No prepaid expenses can be reimbursed before the date the services have been performed.

7.2 **Documentation**.

(a) If a Participant has an eligible medical expense, such Participant must submit a statement from the service provider showing the name and address of the service provider, the date services were performed, type of service(s), and the amount(s) charged.
If the eligible medical expense is covered by the Employer sponsored health or dental care plan or by any other medical or dental plan, a Participant should file a claim first with that plan. The amount not paid by that plan is the amount such Participant can claim for reimbursement. The explanation of benefits form a Participant receives from that other plan detailing what was covered and what the plan pays may be submitted as part of a Participant's medical expense reimbursement claim.

(b) If a Participant has an eligible dependent care expense, such Participant must submit either a statement from the service provider or from himself or herself which shows the name and address of the service provider, the dates on which services were provided, the taxpayer identification number of the service provider (or, if an individual, the individual's social security number) and the amount charged.

If a Participant does not file the appropriate form for reimbursement, or fails to provide the information required to verify that the expense is eligible for reimbursement, payments to such Participant could be delayed or denied.

7.3 **Processing Frequency**. Reimbursement requests are processed as specified in the Adoption Agreement, however, payment will be made only when eligible expenses equal or exceed the minimum reimbursement amount as specified in the Adoption Agreement, except at the end of the Plan Year at which time this minimum will not apply. Reimbursement requests will be paid up to the amount of a Participant's Plan Year election.

7.4 **No Guarantee of Non Tax**. Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts reimbursed to or for a Participant will be excludable from such Participant's gross income for federal or state income tax purposes. It is a Participant's obligation to determine whether each reimbursement is excludable from his or her gross income, and to notify the Plan Administrator if he or she has reason to believe that any such reimbursement is not so excludable.

7.5 **Request for Reimbursement Submissions' Period**. Any eligible expenses, which a Participant incurs during the Plan Year can be submitted for reimbursement at any time during that Plan year. To give a Participant time to file for expenses incurred during the last few months of a Plan Year, a Participant can file for reimbursement during the first ninety (90) days of the following Plan Year.

ARTICLE VIII

TERMINATION OF PARTICIPATION; LEAVES OF ABSENCE

8.1 **Contributions Cease**. A Participant's contributions to the Health Care Expense Reimbursement Account and/or Dependent Care Expense Reimbursement Account, as well as the pre-tax payment of the Employer sponsored Plans Premiums will cease on the earlier of the last day of the payroll period in which a

Participant receives compensation, or the last day of the payroll period in which a Participant ceases to be an Eligible Employee due to:

(a) Participant's termination of employment (voluntary or involuntary), retirement or death;
(b) Participant's absence from work for any reason if Participant's pay stops; or
(c) Participant's reduction in hours worked below the minimum required to participate.

Contributions will also stop at the end of each Plan Year.

8.2 **Participation Ceases**. A Participant's participation ends as specified in the Adoption Agreement.

8.3 **Group Health Plan Continuation Coverage**. Each benefit plan made available under Article VI hereof which is considered to be a "group health plan" under Section 4980B(g)(2) of the Code, because employees and their families are provided with health care benefits within the meaning of Section 5000(b)(1) of the Code, shall contain the necessary provisions required by Section 49808 of the Code and 601 of ERISA, to assure that such benefits may be continued on or after the occurrence of the qualifying events defined in Section 49808(f)(3) of the Code. (See Article IX., "Continuation Coverage," hereof for this Plan's provisions.)

8.4 **Leaves of Absence**. The Plan shall be administered in accordance with the Family and Medical Leave Act of 1993 ("FMLA") as the same may be applicable to the Plan. The Plan Administrator shall prepare and maintain a procedure ("FMLA Procedure") for employee leaves taken pursuant to FMLA which FMLA Procedure, as the same may be amended from time to time, is incorporated herein by reference and made a part hereof.

ARTICLE IX

CONTINUATION COVERAGE

9.1 **Availability of Continued Health Care Expense Reimbursement Account Benefits**. The Health Care Expense Reimbursement Account Benefits will be available to all persons whose health Benefits would otherwise terminate due to a qualifying event described in Sections 9.3 or 9.4 hereof, and who qualify under the terms of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and subsequent related regulations and amendments. Anyone eligible to elect to continue coverage under this Article IX, shall be referred to herein as a "Qualified Beneficiary."

9.2 **Purchase of Health Benefits at 102% of Cost**. A Qualified Beneficiary whose Health Care Expense Reimbursement Account Benefits have been terminated for any qualifying event enumerated in section 9.3 or 9.4 hereof has the right to continue in the Health Care Expense Reimbursement Account for all health care benefits which under the Health Care Expense Reimbursement Account for the Qualified Beneficiary was entitled to receive on the day immediately preceding the date of the qualifying event. The time period for which the continuation coverage is available is indicated below in conjunction with the corresponding qualifying event. One Hundred Two Percent (102%) of the full cost of providing such coverage shall

be charged to any person continuing in the Health care Expense Reimbursement Account. This cost shall be determined at the beginning of each Plan year and shall remain in effect for the remainder of such Plan year.

9.3 **Qualifying Events Triggering Eighteen Months of Continuation Coverage**. An eighteen (18) month continuation of health Benefits shall be available to Qualified Beneficiaries who lose coverage due to one of the following qualifying events.

(a) the termination of employment by a Participant who is an Eligible Employee for any reason except gross misconduct;

(b) the loss of eligibility of a previously eligible Employee to participate in the Health Care Expense Reimbursement Account due to reduced work hours.

9.4 **Qualifying Events Triggering Thirty-Six Months of Continuation Coverage**. A Thirty-six (36) month continuation of health Benefits shall be available to Qualified Beneficiaries who lose coverage due to one of the following qualifying events:

(a) death of a Participant who is an Eligible Employee;

(b) divorce or legal separation from a Participant who is an Eligible Employee;

(c) a covered Dependent child's loss of eligibility to participate in the Health Care Expense Reimbursement Account due to age or a change in student status;

(d) A covered Dependent's loss of eligibility to participate in the Health Care Expense Reimbursement Account due to the Eligible Employee becoming entitled to Medicare.

If a qualifying event listed in this Section 9.4 hereof occurs within the 18-month period described in Section 9.2, the 36-month continuation period shall be deemed to commence as of the date of the qualifying event in Section 9.3 hereof. Solely to the extent required by law, in the case of an event described in Section 9.4 hereof, the period of continuation coverage for covered Dependents for such event or any subsequent qualifying event shall not terminate before the end of the 36-month period beginning on the date the Eligible Employee became entitled to Medicare.

9.5 **Other Qualifying Event Rules**. In the case of any loss of coverage due to the commencement of a bankruptcy proceeding with respect to the Employer, the rules governing the maximum period of continuation coverage under the Code, are hereby incorporated by reference. In the case of a Qualified Beneficiary who is determined to have been disabled (within the meaning of the Social Security act) at the time of a qualifying event described in Section 9.3 hereof, any reference in Section 9.3 hereof to 18 months with respect to such qualifying event is deemed to be a reference to twenty-nine (29) months, but only if the Qualified Beneficiary provides notice of such determination of disability to the Plan Administrator within sixty (60) days of such determination, but not later than the otherwise applicable eighteen (18) month period. Such Qualified Beneficiary must also notify the Plan Administrator of any final determination that he or she is no longer disabled, within thirty (30) days of such final determination.

9.6 **Notification Rules**. The Eligible Employee or Qualified Beneficiary is required to notify the Plan Administrator within sixty (60) days of a qualifying event described in Section 9.4(b) or (c) hereof. If an eligible Employee or Qualified Beneficiary fails to provide such notice, the Qualified Beneficiary shall lose his right to elect continuation of coverage under this Article IX. The Employer is required to notify the Plan Administrator within thirty (30) days of any other qualifying event. The Plan Administrator shall notify each Qualified Beneficiary of his or her right to continuation of coverage within fourteen (14) days of the notice made to the Plan

Administrator of the qualifying event. The Eligible Employee or covered Dependent is also required to provide the Plan Administrator with all information needed to meet its obligation of providing notice and continuation coverage.

9.7 **Termination of Continuation Coverage**. Continuation of the Health Care Expense Reimbursement Account Benefits shall not be provided beyond whichever of the following dates is first to occur:

(a) the date the maximum continuation period expires for the corresponding qualifying event;

(b) the date of termination of the health Benefit elected under the Health Care Expense Reimbursement Account ,together with all other health benefits provided by the Employer that have been continued under continuation of health benefit rules;

(c) the date the eligible Employee or Qualified Beneficiary fails to pay the applicable Health Care Expense Reimbursement Account Contribution on time;

(d) the date the Eligible Employee or Qualified Beneficiary becomes covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Beneficiary;

(e) the date the Eligible Employee or Qualified Beneficiary becomes entitled to Medicare; or

(f) in the case of an extension of coverage under Section 9.5 due to disability, the later of one of the foregoing events described in subparagraphs (a) through (e) or the month that begins more than thirty (30) days after a final determination that the Qualified Beneficiary is no longer disabled.

9.8 **Nonpayment of Health Care Expense Reimbursement Account Contributions**. If any Participant fails to pay on time any applicable contribution to the Health Care Expense Reimbursement Account, the Employer will reduce any reimbursement for eligible health care expenses remaining to be paid to the Participant by the amount of any Health Care Expense Reimbursement Account contributions due for the balance of the Plan Year, as part of the Employer's efforts to collect any overdue unpaid Health Care Expense Reimbursement Account contributions.

ARTICLE X

PLAN ADMINISTRATION

10.1 Administrative Responsibility. The Plan will be administered by the Plan Administrator. It shall be the principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms for the exclusive benefit of the Participants of the Plan. In addition to the provisions set forth herein, the administration of the Plan shall be subject to the terms of any written agreement executed between the Employer and the Plan Administrator in connection with the implementation of the Plan, as such written agreement may be amended from time to time. The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

(a) To construe and interpret the Plan, decide all questions of eligibility, and to determine the amount, manner, and term of payment of any Benefits hereunder;
(b) To prescribe procedures to be followed by the Participants filing applications for Benefits, including modification of any procedures set forth in this Plan;
(c) To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan.
(d) To receive from the Employer and from Participants such information as shall be necessary tor the proper administration of the Plan;
(e) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;
(f) To receive, review and retain reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Plan Administrator;
(g) To appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuary counsel; and
(h) To modify any provision of the Plan if such modification is necessary for the Plan to comply with the Code and the regulations issued thereunder.

The Plan Administrator may rely upon any direction, information, or action of any employee of the Employer as being proper under the Plan and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that the Plan Administrator shall not be responsible for any act or failure to act of any other Employee of the Employer.

10.2 **Appointment of Plan Administrator**. The Employer may designate any person, firm or entity to serve as Plan Administrator. If no such person, firm or entity is named, the Plan Administrator is the Employer. All usual and reasonable expenses of the Plan Administrator shall be paid in whole by the Employer and any expenses not paid by the Employer shall not be the responsibility of the Plan Administrator personally.

10.3 **Bonding**. Unless otherwise determined by the Employer, or unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of the Plan.

10.4 Records and Reports. The Plan Administrator shall exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances which are payable under the Plan.

10.5 **Rules and Decision**. The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate to administer the Plan, and all rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

10.6 Authorization of Benefit Payments. The Plan Administrator may issue directions to the Employer concerning all Benefits, which are to be paid from the Employer's general assets pursuant to the provision of the Plan.

10.7 **Application and Forms for Benefit**. The Plan Administrator may require a Participant to complete and file with the Plan Administrator an application for a Benefit and all other forms approved by the Plan Administrator and to furnish all pertinent information requested by the Plan Administrator. The Plan Administrator

may rely upon all such information so furnished it, including the Participant's current mailing address.

10.8 **Facility of Payment**. Whenever the Plan Administrator's opinion on a person entitled to receive any payment of a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage his or her financial affairs, the Plan Administrator may make payments to such person or to such person's conservator, attorney-in-fact, or other legal representative of such person, or apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the provisions hereof shall be a complete discharge of any liability of the Plan Administrator.

ARTICLE XI

CLAIMS PROCEDURES

11.1 **Procedure If Benefits are Denied Under the Plan**. Any Participant, beneficiary, or his or her duly authorized representative may file a claim for a Plan Benefit to which the claimant believes that he or she is entitled. Such a claim must be in writing and delivered to the Plan Administrator in person or by mail, postage paid. Within ninety (90) days after receipt of such claim, the Plan Administrator shall send to the claimant, by mail, postage prepaid, notice of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed ninety (90) days from the end of the initial period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial ninety (90) day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part. If notice of the denial of a claim is not furnished in accordance with this Section 11.1, the claim shall be deemed denied and the claimant shall be permitted to exercise his or her right to review pursuant to Sections 11.3 and 11.4 hereof.

11.2 **Requirement for Written Notice of Claim Denial**. The Plan Administrator shall provide, to every claimant who is denied a claim for Benefits, a written notice setting forth in a manner calculated to be understood by the claimant:

(a) The specific reason or reasons for the denial;

(b) Specific reference to pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(d) An explanation of the Plan's claim review procedure.

11.3 **Right to Request Hearing on Benefit Denial**. Within sixty (60) days after the receipt by the claimant of written notification of the denial (in whole or in part) of his or her claim, the claimant or his or her duly authorized representative, may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to request a review of such denial. The claimant may review Plan documents in connection with his or her request for review and request a hearing with the Plan Administrator.

11.4 **Disposition of Disputed Claims**. Upon receipt of a request for review, the Plan Administrator shall make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent plan or insurance policy provisions on which the decision was based. The decision upon review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision on the review is not furnished in accordance with this Section 11.4, the claim shall be deemed denied and the claimant shall be permitted to exercise his or her right to legal remedy pursuant to Section 11.5 hereof.

11.5 **Preservation of Remedies**. After exhaustion of the claims procedure as provided under the Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available

ARTICLE XII

MISCELLANEOUS

12.1 **Non-Alienation of Benefits**. Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the Benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge encumbrance, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contract, liabilities, engagements, or torts of any person entitled to Benefits hereunder.

12.2 **No Guarantee of Employment**. Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Employee or as a right of any Employee to be continued in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

12.3 **Amendment or Termination of the Plan**. The Employer has established the Plan with the intent that it will be maintained for an indefinite period of time. The Employer intends that the terms of the Plan, and each Employee's rights thereunder, including those related to coverage and Benefits, shall be legally enforceable and that the Plan shall be maintained for the exclusive benefit of the Employees. Except as provided in Section 10.1 hereof, the right to alter, amend, suspend, or terminate the Plan is reserved to the Employer. If the Plan is terminated, all enrollment elections with respect to the Plan shall terminate.

12.4 **Insurer Not a Party**. No insurer shall be considered a party to the Plan. The rights and obligations of any insurer are those specified in the insurance policy and no provision of the Plan shall be deemed to alter or change the terms of such contract.

12.5 **Notice of Address**. Each person entitled to Benefits under the Plan must file with the Plan Administrator (or designee), in writing his mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the Plan, and there shall be no obligation on the part of the Employer, the Plan Administrator or any trustee or insurer to search for or to ascertain the location of such person.

12.6 **Source of Payments**. To the extent a Participant's salary or wages are reduced to provide non-cash Benefits through the Plan, these reduced amounts become Employer contributions to the Plan. The Employer pays any benefits to which a Participant is entitled under the Plan from its general assets.

12.7 **No Obligation to Insure or Fund Benefits**. The Employer shall have no obligation, but shall have the right, to insure any Benefits under the Plan or to establish any fund or trust for the payment of Benefits under the Plan except as mandated by law.

12.8 **Benefit Funded Through Trust**. In the case of any benefit which is funded through contributions to a trust, any benefits accruing shall be payable solely out of the assets of such trust, and the Employer shall have no responsibility for the payment of such Benefits.

12.9 **Indemnification by Employer**. To the extent allowed by law, the Employer does hereby indemnify and hold harmless any person, corporation, professional association or partnership that is deemed to be a fiduciary of the Plan under the terms and provisions of ERISA, the regulations promulgated thereunder and case law which develops, against any and all losses, claims, damages, expense (including court costs and attorney's fees) and liability arising from their duties and responsibilities in connection with the Plan unless the same is due to willful or wanton misconduct.

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

12.11 **Applicable Law**. The Plan shall be construed and interpreted in accordance with the laws of the State of Oklahoma to the extent the terms thereof are not preempted by the law of the United States

12.12 **Captions**. The captions or heading in the Plan are made for convenience and shall not be construed to describe, define or limit the scope or intent of the Plan.

12.13 **Severability**. Should any part of the Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extend possible.

Exhibit A

Dependent Care Reimbursement Plan

Dependent Care Reimbursement Plan

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Dependent Care Reimbursement Plan

RECITALS

WHEREAS, The Employer, desires to sponsor a dependent care expense reimbursement plan ("Dependent Care Reimbursement Plan") pursuant to Sections 125 and 129 of the Internal Revenue Code of 1986, as amended ("Code") for the benefit of certain of its employees; and

WHEREAS, the Employer desires to adopt the Dependent Care Reimbursement Plan on the Effective Date of the Flexible Spending Plan to which this Exhibit "A" is attached ("Flexible Spending Plan");

NOW, THEREFORE, the Employer does hereby agree as follows:

ARTICLE I

DEFINITIONS

When used herein, capitalized words and phrases shall have the meanings as defined in Article I of the Flexible Spending Plan to which this Exhibit "A" is attached. Further, any references in the Flexible Spending Plan to the "Plan" shall be construed to include the Dependent Care Reimbursement Plan where such meaning is appropriate.

ARTICLE II

PURPOSE AND EFFECTIVE DATE OF THE PLAN

2.1 Purpose. The Dependent Care Reimbursement Plan is intended to qualify both as a nondiscriminatory salary reduction cafeteria plan under section 125 of the Code and as a dependent care assistance program under Section 129 of the Code; and that reimbursements under the Dependent Care Reimbursement Plan be eligible for exclusion from Participants' income under Section 129 of the Code. Accordingly, the Dependent Care Reimbursement Plan shall be interpreted and construed in accordance with all such sections of the Code and the regulations issued thereunder.

2.2 Separate Plan Documents. The Benefits offered under the Dependent Care Reimbursement Plan may be the subject of separate plan documents, agreements, policies and contracts and are incorporated herein by reference as the same may be changed from time to time. In the event of a conflict between the terms of the Dependent Care Reimbursement Plan and the terms of another plan contract, the terms of the Dependent Care Reimbursement Plan shall control.

2.3 Name. The Dependent Care Reimbursement Plan shall be referred to as the Dependent Care Reimbursement Plan.

2.4 Effective Date. The effective date of the Dependent Care Reimbursement Plan is the Effective Date of the Flexible Spending Plan.

ARTICLE II

ELIGIBLE FOR PARTICIPATION

Eligibility for participation shall be as provided in Article III of the Flexible Spending Plan.

ARTICLE IV

SALARY REDIRECTIONS

Salary redirections shall be as provided in Article IV of the Flexible Spending Plan.

ARTICLE V

PARTICIPATION, ELECTION AND CONTRIBUTIONS

Participation, election and contributions shall be as provided in Article V of the Flexible Spending Plan.

ARTICLE

VI

BENEFITS

6.1 Generally. The amount a Participant has elected on his or her Salary redirection Agreement to be applied to his or her Dependent Care Expense Reimbursement Account will be used to reimburse such Participant for eligible dependent care expenses.

6.2 Eligible Dependent Care Expenses. Eligible dependent care expenses are those expenses that would be considered "employment-related expenses" under Section 21(b)2 of the Code (relating to expenses for household services and for the care of a qualifying dependent which are necessary for gainful employment) if paid for by a Participant.

6.3 Limitations on Eligible Dependent Care Expenses. There are a few limitations on eligible dependent care expenses.

(a) Expenses must be incurred for household services or for the care of one or more members of a Participant's home who are "Qualifying Dependents." A Qualifying Dependent is:

A Participant's Dependent under age thirteen (13) with respect to whom the Participant is entitled to an exemption deduction under Section 151(c) of the Code;

(ii) A Participant's Dependent who is physically or mentally incapable of caring for himself or herself;

(iii) A Participant's spouse who is physically or mentally incapable of caring for himself or herself;

(b) They must be expenses which are not paid or reimbursed through another benefit plan from any other source;

(c) Expenses must be incurred during the Plan Year for which a Participant's election is made (expenses are treated as incurred on the date the services are provided);

(d) Expenses must be incurred while the Participant is participating in the Dependent Care Reimbursement Plan;

(e) The total amount of reimbursements made in a taxable year, under this and any other dependent care plan, cannot exceed a Participant's earned income (or if a Participant is married, the lesser of such Participant's earned income, or his or her spouse's earned income), during that taxable year;

(f) The expenses are necessary to enable a Participant and his or her spouse (if married) to be gainfully employed;

(g) A Participant's spouse must work outside the home, be a Full Time Student or by physically or mentally incapable to care for himself or herself.

(h) If services were provided outside the participant's home, such services must be incurred for the care of a Qualifying Dependent who is under the age of 13, or for any other Qualifying Dependent who regularly spends at least (8) hours a day in the Participant's household;

(i) Services rendered in a Dependent Care Center as defined in Section 21(b)(2)(D) of the Code must satisfy the requirements of Section 21(b) of the Code and the regulations issued thereunder;

(j) The person providing the service to a Participant's Qualifying Dependent cannot be (i) an individual with respect to whom a deduction is allowable under Section 151(e) of the Code to such Participant or his or her spouse; (ii) such Participant's spouse; or (iii) a child of such Participant who is under 19 years of age at the end of the Plan Year in which the service is provided; and

(k) A Participant will not take a tax credit on his or her income tax return for the expenses, which are reimbursed under the Dependent Care Reimbursement Plan.

6.4 Limitation of Benefits. Limitation of Benefits shall be as provided in Section 6.6 of the Flexible Spending Plan.

6.5 Limitation of Benefits for Highly Compensated Employees. No Dependent Care Reimbursement Plan Benefit will be provided to "Highly Compensated Employees" within the meaning of Section 414(q) of the Code, to the extent that the average of Benefits provided under the Dependent Care Reimbursement Plan to Employees who are not Highly Compensated Employees would be less than 55% of the average of Dependent Care Reimbursement benefits provided to Highly Compensated Employees. Further, not more than 25% of the total Benefits paid from all of the Dependent Care Reimbursement Accounts during any Plan Year may be paid to any Participant who owns directly or indirectly, more than 5% of the stock or capital of profits interest of the Employer on any day during the Plan Year, or to any Participant who is a spouse or a dependent of any such individual.

6.6 Statement of Benefits. Statement of Benefits shall be as provided in Section 6.7 of the Flexible Spending Plan.

6.7 Nature of Account. Nature of Account shall be as provided in Section 6.8 of the Flexible Spending Plan.

6.8 Forfeitures. Forfeitures shall be as provided in Section 6.9 of the Flexible Spending Plan.

ARTICLE VII

REIMBURSEMENT PROCEDURES

Reimbursement Procedures shall be as provided in Article VII of the Flexible Spending Plan.

ARTICLE VIII

TERMINATION OF PARTICIPATION

Termination of Participation shall be as provided in Article VIII of the Flexible Spending Plan.

ARTICLE IX

PLAN ADMINISTRATION

Plan Administration shall be as provided in Article X of the Flexible Spending Plan.

ARTICLE X

CLAIMS PROCEDURES

Claims Procedures shall be as provided in Article XI of the Flexible Spending Plan.

ARTICLE XI

MISCELLANEOUS

Miscellaneous provisions shall be as provided in Article XII of the Flexible Spending Plan.

Adoption Agreement

The name of the Plan is:

City of Norman, Oklahoma Flexible Spending Plan

City of Norman, Oklahoma
(Premium/Health/Dependent Care)
Amended December 13, 2022

Adoption Agreement

I. EMPLOYER INFORMATION

A. EMPLOYER'S BUSINESS NAME, ADDRESS AND TELEPHONE NUMBER:	BUSINESS NAME:	CITY OF NORMAN OKLAHOMA
	STREET ADDRESS:	BOX 370
	CITY. STATE, ZIP CODE:	NORMAN, OK 73070
	TELEPHONE NUMBER:	(405) 366-5486
B. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER:	73-6005350	
C. THE EMPLOYER IS:	MUNICIPALITY	

II. PLAN INFORMATION

A. PLAN ADMINISTRATOR The Plan Administrator will be the employer, unless another person, firm or entity identified has been appointed.	Name: Street Address: City, State, Zip Code: Telephone Number:	City of Norman, Oklahoma P.O. Box 370 Norman, Oklahoma 73070 (405) 366-5413
B. AGENT FOR SERVICE OF LEGAL PROCESS: The Agent for Service of Legal Process will be the Plan Administrator, unless another person identified has been designated.	Name: Street Address: City, State, Zip Code:	Ms. Kathryn Walker P.O. Box 370 Norman, Oklahoma 73070
C. AMENDMENT OF AN EXISTING PLAN.	Original Effective Date of Prior Plan:	February 1, 1992
	Effective Date of Amended Plan:	January 1, 2023
D. PLAN YEAR	The Plan Year begins on the Effective Date and ends on December 31st of that same year with respect to the initial Plan Year. and thereafter shall begin on January 1 and end on December 31st.	

III. ELIGIBILITY FOR PARTICIPATION

A. **Eligible Employee.**

All full-time regular employees of the Employer working at least thirty (30) hours a week are eligible to participate in the Plan.

B. **Eligibility Begins**.

- Initial Enrollment. Eligibility begins on the later of (i) the same date as an Eligible Employee's eligibility begins in the Employer-sponsored Core Health Care Plan (see IV. Employer-Sponsored Plans, below); or (ii) the Effective Date.
- New Employees. Eligibility begins on the same date as his or her eligibility begins in the employer-sponsored Core Health Care Plan (see IV. Employer-Sponsored Plans, below).

C. **Rehired Employees**.

If a Participant's employment ends and such participant is rehired prior to the end of the same Plan year, such participant will not be allowed to participate in the Plan until the Plan Year following said participant's separation from service except, that if such Participant is enrolled in the Health Care Expense Reimbursement Account when his or her employment ends, such Participant will remain a Participant in that account for the remainder of that Plan Year in accordance with Section 8.2 of the Plan Document. If a former Participant is rehired in a Plan Year following the Plan Year during which the former Participant's employment ends, such former Participant is eligible to participate in the Plan in the same manner as any new Employee.

IV. EMPLOYER-SPONSORED PLANS

The premium costs of the following Employer-sponsored Plans may be paid through the Pre-tax Premium Account:

Core Health Plan.

Name of Plan: City of Norman Group Health and Dental Plan

V. REIMBURSEMENT ACCOUNTS

A. **Minimum Annual Contributions.**

None.

8. Maximum Annual Contributions.

1. Health Care Expense Reimbursement Account - $3,050

2. Dependent Care Reimbursement Account - $5,000

VI. REIMBURSEMENT PROCEDURES

A. **Expense Reimbursement Request.** Participants should forward their Expense Reimbursement Request form to:

Name:	City of Norman - Payroll Department
Address:	P.O. Box 370
City, State, Zip Code:	Norman, OK 73070

B. **Processing Frequency** Two (2) Week Cycle.

C. **Minimum Reimbursement Amount** $5.00.

VII. TERMINATION OF PARTICIPATION

A. **Participation Ceases.**

Pre-Tax Premium Account – A Participant's participation ends when his or her contributions cease as provided in Section 8.1 of the Plan Document.

Health Care Expense Reimbursement Account - A Participant will remain a Participant in the Health Care Expense Reimbursement Account for the remainder of the Plan Year. However, in order to continue to be reimbursed for expenses incurred after a Participant's contributions cease, such Participant must prepay the unpaid balance of his or her annual Health Care Expense Reimbursement Account election for the Plan Year. Such prepayment may, upon a Participant's written direction, be deducted with before-tax dollars from such Participant's final paycheck (or from the last paycheck proceeding the effective date of his or her reduction in hours).

If a Participant does not elect to have the remainder of such Participant's current Plan Year's annual Health Care Expense Reimbursement Account election deducted from his or her final paycheck, or if his or her final paycheck is insufficient to prepay the remaining election, he or she must pay this amount with after-tax dollars to the Plan Administrator, within thirty (30) days of his or her termination of employment or reduction in hours.

Until the unpaid balance of a Participant's annual election is paid, reimbursement payments to such Participant shall not be made with respect to any health care expense incurred after the date contributions cease.

Once the balance of a Participant's annual election is paid, such Participant's participation will continue uninterrupted until the end of the Plan Year in the same manner as while he or she was employed (see also Article IX, "Continuation Coverage," of the Plan Document).

Dependent Care Expense Reimbursement Account – A Participant's participation ends when such contributions cease as provided in Section 8.1 of the Plan document. A Participant may continue to file claims for reimbursement until (90) days following the end of the Plan Year for eligible expenses incurred **prior** to the date such Participant's contributions ceased.

The Employer hereby adopts or amends the Flexible Spending Plan and Dependent Care Reimbursement Plan as of the Effective Date.

"Employer"
City of Norman, Oklahoma

By:_____

Title: ——————————

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