



FSA and HSA Administration Services

Request for Proposal #20-25-208266

June 30, 2020

Alaska Railroad Corporation
327 W. Ship Creek Avenue, Anchorage, AK 99501
P.O. Box 107500, Anchorage, AK 99510-7500

Email: Goemerg@akrr.com



ALASKA RAILROAD CORPORATION
327 W. Ship Creek Ave.
Anchorage, AK 99501

June 30, 2020

REQUEST FOR PROPOSAL # 20-25-208266

FSA and HSA Administration Services

Response Requested,

This form must be completed and returned to ensure receipt of future addenda or additional information, email to: Goemerg@akrr.com. All addenda will be forwarded to the contact name and number listed below.

Firms that have not returned this cover sheet will not be informed of addendums and will only be alerted to addendums by checking with the ARRC procurement officer or by checking ARRC's internet site: www.alaskarailroad.com, select Suppliers and then Solicitations. Bidders must acknowledge the receipt of all issued addendums in their proposal/bid submittal.

Company _____

Address _____

Contact _____

Phone _____

Fax _____

Email _____

Website: www.alaskarailroad.com



ALASKA RAILROAD CORPORATION
327 W. Ship Creek Ave.
Anchorage, AK 99501

June 30, 2020

REQUEST FOR PROPOSAL #20-25-208266

The Alaska Railroad Corporation (ARRC) is soliciting proposals from interested concerns for the following:

Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) Administration Services

OFFERS WILL BE RECEIVED AT: Alaska Railroad Corporation
Attn: Greg C. Goemer
327 West Ship Creek Avenue,
Anchorage, Alaska 99501
Email : Goemerg@akrr.com

Proposals shall be received until July 30, 2020 3:00p.m. local time. Detailed instructions for submitting responses are outlined in this document. The envelope used in submitting your firm's offer shall be plainly marked with the following information:

1. Offeror's Name -
2. RFP # 20-25-208266
3. FSA and HSA Administration Services

The Alaska Railroad may award a contract resulting from this solicitation to the responsible offeror whose offer conforming to this solicitation will be most advantageous to the Alaska Railroad. The Alaska Railroad may reject any or all offers if such actions is in the best interest of Alaska Railroad, and waive informalities and minor irregularities in offers received.

This Request for Proposal is not to be construed as a commitment of any kind nor does it commit the Alaska Railroad to pay any costs incurred in the submission of an offer or for any other costs incurred prior to the execution of a formal contract.

Proposals received after the time and date set forth above shall be rejected. All proposals submitted in response to this solicitation must be signed by an individual with the legal authority to submit the offer on behalf of the company.

Bidder's responsibility: ARRC shall not be held responsible for Bidder's lack of understanding of what is required by this bid. Should a Bidder not understand any aspect of this bid, or require further explanation, or clarification regarding the intent or requirements of this bid, it shall be the responsibility of the Bidder to seek guidance from the ARRC.

Each Proposer shall indicate all exceptions to terms, conditions, and specifications of this solicitation individually in its proposal. **IMPORTANT:** Exceptions other than those not allowed by law will be rejected. Exceptions received or placed after the proposal submission date will be considered as counter offers and as such will render the entire proposal non-responsive.

Protests Per ARRC Procurement Rule 1800.2

A protest based on alleged improprieties or ambiguities in a solicitation must be filed at least 10 days before the due date of the bid or proposal, unless a later protest due date is specifically allowed in the solicitation. If a solicitation is made with a shortened public notice period and the protest is based on alleged improprieties or ambiguities in the solicitation, the protest must be filed before the due date of the bid or proposal.

The protest of an invitation to bid or a request for proposals in which a pre-bid or pre-proposal conference is held within 12 days of the due date must be filed before the due date of the bid or proposal if the protest is based on alleged improprieties or ambiguities in the solicitation. A protest based upon alleged improprieties in an award of a contract or a proposed award of a contract must be filed within 10 days after a notice of intent to award a contract is issued by the procurement officer



The Alaska Railroad is a member of Green Star (<http://www.greenstarinc.org/>). ARRC earned an initial Green Star Award in 1994 and a Green Star Air Quality Award in 2007. The Alaska Railroad considers Green Star membership to be a positive business attribute, and regards a Green Star award as a tangible sign of an organization's commitment to environmental stewardship and continual improvement within its operations.

Please direct all responses to this solicitation and/or questions concerning this Request for Proposal to Greg C. Goemer, Alaska Railroad Corporation, 327 Ship Creek Avenue, Anchorage, AK 99501. Questions may be emailed to goemerg@akrr.com

Best Regards,

Greg C. Goemer
Sr. Contract Administrator.
Alaska Railroad Corporation

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APPENDIX A

Scope of Services

The purpose of this Request for Proposal (RFP) is to provide qualified vendors with information to enable them to prepare and submit competitive Proposal to administer the following programs:

- Section 125 Cafeteria Plan:
 - Health Care Flexible Spending Account (FSA)
 - Dependent Day Care FSA
 - Section 125 Cafeteria Plan Documentation
 - Section 125 Cafeteria Plan Non-Discrimination Testing
- Health Savings Account (HSA)

In addition, the services below are sought:

- Claims processing and reimbursement.
- Compliance assistance.
- Consultation services regarding the Internal Revenue Code and regulations that apply to cafeteria plans.
- Customer service.
- Enrollment and eligibility activities.
- Implementation and vendor roll-out.
- Ongoing member communication and education.
- Support for the Railroad's payroll, human resource office.
- Proactive account management.
- Reporting- monthly, quarterly and annual.

The Railroad's objective is to establish a long-term partnership with a Contractor for the administration of the HSA and FSA.

Proposers must be able to provide all services for the programs proposed and meet all the requirements requested in the RFP. The Contractor shall remain responsible for Contract performance regardless of any services performed by its Subcontractor(s). All offerings described in the Proposal must be available to all eligible participants. The selected Contractors Proposal will become part of the contract with the Railroad.

CORPORATE BACKGROUND INFORMATION

The Alaska Railroad Corporation is a public corporation created by the State of Alaska pursuant to AS 42.40 to own and operate the Railroad and manage the Railroad's properties. The Alaska Railroad is the last full service (passengers and freight) Railroad in the United States, with a route that runs from Seward and Whittier at tidewater to interior Alaska just beyond Fairbanks. The corporation is headquartered in Anchorage, with work stations in Anchorage, Fairbanks, Nenana, Healy, Denali National Park, Cantwell, Talkeetna, Wasilla, Seward, and Whittier, as well as a two-person office in Seattle, WA. The ARRC averages approximately 600 employees (year-round and seasonal), with employment reaching about 750 in the summer season. Seventy-five percent (75%) of ARRC employees are represented by one of five (5) unions: Alaska Railroad Workers (ARW), American Train Dispatchers (ADTA), International Brotherhood of Teamsters (IBT), Transportation Communications Union (TCU), and United Transportation Union (UTU). The remaining employees are non-represented management personnel. The Railroad bargains benefit matters with all five labor organizations.

As the ARRC is a public corporation of the State of Alaska, its benefits plans are governmental plans and not subject to the provisions of ERISA. Even though ARRC is an ERISA-exempt organization, proposers should be mindful that adherence to ERISA guidelines.

ADDITIONAL BACKGROUND INFORMATION

The links below provide additional information about the Railroads benefit programs.

- Health Plan Information
 - <https://insidetrack.akrr.com/Benefits/Health-Insurance-Benefits>
- Health Saving Accounts (HSA)
 - <https://insidetrack.akrr.com/Benefits/Flexible-Spending>
- Health Care & Dependent Care Flexible Spending Accounts (FSA)
 - <https://insidetrack.akrr.com/Benefits/Flexible-Spending-Accounts>

ELIGIBILITY AND PARTICIPATION HSA AND FSA

The HSA is available to all employees if they enroll in the HDHP and the Medical FSA is available to all employees enrolled in the PPO plan. The dependent care FSA is available to all employees.

Historical Contributions

	June 2015	June 2016	June 2017	June 2018	June 2019	May 2020
<i>Medical FSA</i>	\$105,640	\$49,262	\$112,620	\$42,838	\$34,741	\$89,990
<i>Dependent Care FSA</i>	\$18,461	\$37,500	\$30,000	\$21,637	\$6,300	\$16,400
<i>HSA</i>	\$61,284	\$66,348	\$78,195	\$100,725	\$106,614	\$121,686

Historical Enrollment

	June 2015	June 2016	June 2017	June 2018	June 2019	May 2020
<i>Medical FSA</i>	54	61	60	57	47	49
<i>Dependent Care FSA</i>	4	8	6	6	2	6
<i>HSA</i>	80	112	123	142	160	162

Employee Eligibility

An eligible Employee may enroll in an HSA or FSA program within 31 days of their hire date of eligibility date or during an annual open enrollment period generally held from most years from November 15 to December 15. If an Employee does not enroll within 31 days of their hire date or during the annual open enrollment period, they are not eligible to enroll until the next open enrollment period, unless they experience a qualifying life event. Documentation supporting the changes due to a qualifying life event must be submitted to the human resource/benefits office for processing.

HSA and FSA program contributions

Employee HSA and FSA program contributions are deducted evenly over the course of the Plan Year, in accordance with the Railroads payroll schedule. All employees are paid Bi-weekly (Exhibit 1).

HSA PROGRAM OVERVIEW

The Alaska Railroad instituted a High Deductible Health Plan (HDHP) and Health Savings Account (HSA) benefit offering in 2015. The HSA program currently offers debit card access to funds and manual reimbursement of expenses. The oversight authority for the program rests with the Alaska Railroads Human Resources Department. The Contractor is also responsible for assuring that they are compliant with the plan document and applicable laws.

HSA ADMINISTRATIVE EXPENSES

Active employees do not pay a fee to participate in the HSA program. The Alaska Railroad will pay the fee for active employees. Employees who are not actively participating in the Railroads HDHP either because they terminate or switch to a PPO plan have the monthly fee paid from their HSA account balance. The current fee is \$2.25 per month.

HSA CONTRIBUTION LIMITS

The Internal Revenue Code sets limits on the amount an Employee may contribute into the HSA program. These limits are adjusted by the Railroad as the Internal Revenue Code changes.

HSA EMPLOYER CONTRIBUTION

Employees receive the HSA Employer contribution for any coverage month in which the employee is enrolled in the HDHP and HSA program.

The 2020 annual HSA Employer contribution for employees is:

- \$500 for single coverage
- \$1,000 for employee plus 1
- \$1,500 for employee plus two or more

For most participants, ARRC will contribute 50 percent of the above amount in January and 50 percent in July. ARRC contributions are prorated for new and seasonal employees, and for employees returning from a layoff, based on the number of pay periods, each employee is enrolled in the HDHP (Exhibit 2).

If an employee changes their health insurance coverage level (for example single to employee + 1), the employee will receive the HSA Employer contribution associated with the health insurance coverage level prorated for the balance of the year.

HSA claims processing

The participant has two (2) options for accessing their HSA funds:

- Debit Card: Participants can use their HSA debit card at the point-of-purchase. The debit card pays for and automatically substantiates the eligible expense, eliminating the need to submit a reimbursement request.
- Request a Reimbursement: Participants can submit a request for reimbursement to the Contractor using one (1) of the following methods:
 - Mobile application
 - Online account
 - Reimbursement Request form

Participants will only be reimbursed for expenses if they have sufficient funds in their HSA account.

The Contractor is responsible for receiving, properly authorizing, processing reimbursement claims for valid reimbursement expenses, and ensuring that all claims authorized for reimbursement are in compliance with all Federal requirements.

The Contractor will process all HSA claims and issue a reimbursement check or electronic funds transfer to program participants within five (5) business days of receipt of a valid and complete reimbursement claim. The Contractor is responsible for resolving all service issues related to reimbursement accounts, including check issuance, direct deposit, stop payments, etc.

FSA ADMINISTRATION

The Cafeteria Plan is an optional benefit program established for eligible employees who are enrolled in the PPO plan. The FSA program was established in the early 2000's under Sections 125, 105, and 129 of the Internal Revenue Code.

The FSA program offers Railroad employees the ability to elect pre-tax deductions for qualified health care and dependent daycare expenses. The program currently provides debit card access to funds and reimbursement of expenses.

The oversight authority for the Section 125 Cafeteria Plan and FSA program rests with the Alaska Railroads Human Resources Department. The Contractor is primarily responsible for claims processing and reimbursement services. The Contractor is also responsible for assuring that they are compliant with the plan documentation, IRS regulations, and for completing non-discrimination testing on an annual basis.

FSA ADMINISTRATIVE EXPENSES

Employees pay a fee to participate in the FSA program. The monthly administrative expense charged to employees is \$2.60. If they have both the Health FSA and the Dependent care FSA there is an additional monthly charge of \$1.20

FSA EMPLOYEE ELIGIBILITY AND PARTICIPATION

The FSA program is available to all full-time employees in the PPO plan. Employees who are classified as seasonal do not participate.

GRACE PERIOD

The Railroad has instituted a grace period for the Health Care FSA. Any previous year's FSA funds for eligible expenses incurred through March 15 must be filled for reimbursement by April 30. Any unused Health Care FSA funds that remain unused are forfeited back to the program and held in trust by the Railroad.

No carryover funds are permitted for the Dependent Day Care FSA. Any unused Dependent Day Care FSA funds at the close of the Plan Year are forfeited back to the program and held in trust by the Railroad.

FSA CLAIMS PROCESSING

The Contractor is responsible for receiving, properly authorizing, and processing reimbursement claims for valid reimbursement expenses and ensuring that all claims approved for reimbursement are in compliance with IRS Code.

The participant has two (2) options for accessing their FSA funds:

- Debit Card: Participants can use their FSA program debit card at the point-of-purchase. The debit card pays for and automatically substantiates some eligible expenses, limiting the need to submit a Reimbursement Request.
- Request a Reimbursement: Participants can submit a request for reimbursement to the Contractor using one (1) of the following methods:
 - Mobile application
 - Online account
 - Reimbursement Request form

The Contractor will process all claims and issue a reimbursement check or electronic funds transfer to participants within five (5) business days of receipt of a valid and complete reimbursement claim. The Contractor is responsible for resolving all service issues related to reimbursement accounts, including check issuance, direct deposit, stop payments, etc.

FSA SUBSTANTIATION

Depending on where a participant tries to use their FSA program debit card, there may be instances where the FSA program debit card transaction will be processed without being verified as an eligible expense at the point-of-sale. In the event the FSA program debit card transaction processed at the point-of-sale without being verified, the participant will receive a notification from the Contractor informing them that their FSA program debit card transaction requires substantiation. Substantiation consists of providing documentation, such as an itemized statement, detailed receipt, or an Explanation of Benefits (EOB) to verify that the transaction is an eligible expense according to IRS regulations.

Claims that are not auto-substantiated are automatically entered into a progressive process:

1. Substantiation notification
2. Claim denial and card deactivation
3. Plan correction payroll withholding
4. Offset approach
5. Recovery as other business debt

FSA NON-DISCRIMINATION TESTING

The Contractor will conduct annual IRC Section 105(h) compliance non-discrimination testing for the Railroad. The Contractor will work with the railroad and payroll during the implementation process to determine a schedule and method for the testing. The Railroad will set a due date for the test results during the implementation and then will provide a due date annually along with other reporting due dates for subsequent years.

HSA and FSA SERVICES PROVIDED TO THE ALASKA RAILROAD

The Contractor provides a central point of contact for employer issues related to the HSA program. The Contractor will provide continuing program support services to the Alaska Railroad Human Department and the Payroll Department.

HSA and FSA CUSTOMER SERVICE

The Contractor should provide a toll-free customer service line dedicated to the Alaska Railroad's HSA and FSA programs. The customer service center responds to participants' inquiries regarding account balances, enrollment, program information, forms completion, and complaints. The volume of calls from Alaska Railroad employees to customer service is unknown.

The current customer service telephone line is available from 8 a.m. to 5 p.m. Alaska time each business day.

Participants have access to their personal account information 24 hours a day, 7 days a week, via the participant online account or mobile application. The online account and/or mobile app allows participants to view their deposits, claims status, account balances, and additional account information.

HSA and FSA RECORD-KEEPING, ACCOUNTING, AND REPORTS

The Contractor performs all administrative and record-keeping functions necessary to ensure accurate disbursement of participant contributions and accurate accounting of participant accounts. The Contractor maintains accounting records at the plan level, recording all fund transactions between payroll processing and the Contractor at the Employee level, and recording transactions for each participant. The Contractor will conduct a monthly reconciliation of accounts and send the resulting report to the Alaska Railroads Human Resources Department and the Payroll Department for review.

The Contractor will furnish the Alaska Railroads Human Resources Department and the Payroll Department annually with a copy of the Contractor's Independent Service Auditors Report.

APPENDIX B

PROPOSAL INFORMATION, CONDITIONS & INSTRUCTIONS

1. Pre-Submission Proposal Inquires

Proposers shall promptly notify ARRC of any ambiguity, inconsistency, conflict, or error which they may discover upon examination of the solicitation documents. Verbal inquiries regarding this RFP are not permitted. All inquiries must be made in writing and received at ARRC's offices prior to July 21, 2020 and the written inquiries must be submitted as follows:

Greg C. Goemer, Alaska Railroad Corporation, 327 Ship Creek Avenue, Anchorage, AK 99501,
Questions may be emailed to: goemerg@akrr.com

ARRC will respond to all or part of the written inquiries received through the issuance of a written Addendum to the RFP, if in the opinion of ARRC, such information is deemed necessary to submit proposals or if the lack of it would be prejudicial to other prospective proposers. Oral and all other non-written responses, interpretations and clarifications shall not be legally effective or binding. Any Proposer who attempts to use or uses any means or method other than those set forth above to communicate with ARRC or any director, officer, employee or agent thereof, regarding this RFP shall be subject to disqualification.

2. Proposal Submission Deadline

Sealed proposals must be received by ARRC no later than July 30, 2020 3:00 p.m., local time, on at:

Alaska Railroad Corporation
327 W. Ship Creek Avenue,
Anchorage, AK 99501

One original proposal should be submitted. Additionally the proposal shall be uploaded to a file hosting site provided by ARRC. The link to the hosting site will be provided to the email address provided on page 1. The envelope or package used in submitting a proposal shall be clearly marked with the following information:

1. Proposer's Name
2. RFP Number 20-25-208266
3. Date and Time Scheduled for Receipt of Proposals

Proposals received after the time and date set forth above shall be rejected. All proposals submitted in response to this solicitation must be signed by an individual with the legal authority to submit the offer on behalf of the company.

3. Proposal Open and Subject to Acceptance

All proposals shall remain open and subject to acceptance by ARRC for 60 (60) days after the deadline for proposal submission.

4. Proposal Opening

Proposals will be opened privately at ARRC's convenience on or after the proposal due date.

5. Reserved Rights

In addition to other rights in this RFP, ARRC reserves, holds and may exercise at its sole discretion, the following rights and options:

- (a) To supplement, amend, or otherwise modify or cancel this RFP with or without substitution of another RFP.
- (b) To issue additional or subsequent solicitations for proposals.
- (c) To conduct investigations of the Proposers and their proposals.
- (d) To clarify the information provided pursuant to this RFP.

- (e) To request additional evidence or documentation to support the information included in any proposal.
- (f) To reject any and all proposals, or parts thereof, and/or to waive any informality or informalities in any of the proposals or the proposal process for the RFP, if such rejection or waiver is deemed in the best interest of ARRC.
- (g) To award a contract or contracts resulting from this solicitation to the responsible Proposer whose proposal conforming to this solicitation will be most advantageous to ARRC.
- (h) To negotiate any rate/fee offered by a Proposer. ARRC shall have the sole right to make the final rate/fee offer during contract negotiations. If the selected Proposer does not accept ARRC's final offer, ARRC may, in its sole discretion, reject the proposal and start negotiations with the next highest ranked Proposer.
- (i) If an award is made and, prior to entering into a contract, subsequent information indicates that such award was not in the best interest of ARRC, ARRC may rescind the award without prior notice to proposers and either award to another proposer or reject all proposals or cancel the RFP.
- (k) To terminate the contractor at any point in the evaluation process or after award if the approved personnel become unavailable, are switched off project by the firm, or the qualifications are generally found to be inadequate. All personnel reassignments to and from the project will be approved by ARRC.

6. Proposal Costs

Each Proposer shall be solely responsible for all costs and expenses associated with the preparation and/or submission of its proposal, and ARRC shall have no responsibility or liability whatsoever for any such costs and expenses. Neither ARRC nor any of its directors, officers, employees or authorized agents shall be liable for any claims or damages resulting from the solicitation or collection of proposals. By submitting a proposal, Proposer expressly waives (i) any claim(s) for such costs and expenses, and (ii) any other related claims or damages.

7. Taxes

Pursuant to AS 42.40.910, ARRC is exempt from all forms of state or local sales, property and other taxes. Accordingly, any Proposer who submits a proposal shall not include any such tax in any of its proposal prices or in any calculation thereof.

8. Proposal Format

Interested firms shall submit one proposal containing a statement of qualifications and a concise narrative that fully addresses each evaluation criteria. Proposals shall have a maximum of twenty (20) pages, exclusive of resumes and exhibits. A signed cover letter of a maximum two (2) pages should introduce the proposed firm, summarize the main qualifications of the firm, and include any other information the Proposer deems will emphasize the Proposer's ability to successfully perform the services required and demonstrate why selection of Proposer would be advantageous to ARRC. A limited number of larger (11x17) sheets are acceptable for graphics or charts. The page limit excludes cover sheets, cover letter, table of contents, forms required by ARRC, resumes or other attachments required herein.

9. Capacity to Perform

Any Proposer considered for award as a result of this solicitation may be required to make assurance to the Contract Administrator concerning the Proposer's capacity and capability to perform. Previous contracts of a like nature, financial solvency, and other information may be requested of the considered Proposer. Failure to provide assurances requested in a timely manner may be cause for rejection of the Proposal.

10. Costs

Other direct costs (ODC) on contracts incurred shall be billed at cost. Any travel and travel related expenses shall be billed at cost with coach airfare only, no first class or business class. Lodging and meal expenses must be reasonable. ARRC will not pay for alcohol, valet parking or other expenses it considers to be exorbitant.

11. Purchase Obligation

ARRC and responding firms expressly acknowledge and agree that ARRC has made no express or implied promises to expend any dollar amounts with respect to the services addressed by this RFP. By submitting a proposal in response to this RFP, each firm acknowledges and agrees that the provisions of this RFP, and/or any communication, statement, act or omission by representatives of ARRC (including consultants) in the selection process, shall not vest any right, privilege, or right of action in any Proposer.

12. Exceptions to Terms, Conditions and Specifications

Any contract resulting from this solicitation shall incorporate the General Terms and Conditions contained in this solicitation package. Each Proposer shall indicate all exceptions to terms, conditions, and specifications of this solicitation individually in its proposal. Exceptions received or placed after the proposal submission date will be considered as counter offers and as such will render the entire proposal non-responsive.

13. Public Information

All submitted proposals will be considered confidential until notice of intent to award is issued. After notice of intent to award is issued, all proposals will become public information.

14. Qualifications of Proposers

Proposers will be evaluated by ARRC based upon their experience in performing the services requested, financial stability, appropriate personnel, responsiveness, technical knowledge and general organization. ARRC reserves the right to take any actions it deems necessary to determine if Proposers have the ability to perform the services outlined in the Scope of Work in a satisfactory manner. Such actions will include an evaluation of the Proposer's qualifications and references prior to Contract Award. Proposers may be disqualified, and their Proposals rejected, for any reason deemed appropriate by ARRC including, but not limited to, the following:

- (a) Evidence of collusion between a Proposer and any other Proposer(s).
- (b) An unsatisfactory performance record on prior projects for ARRC, or any other organization.
- (c) The appearance of financial instability (in the opinion of ARRC) and/or evidence that Proposer may not be financially able to complete the work required by the Scope of Work in a satisfactory manner.
- (d) If Proposer has failed to complete one or more public contracts in the past.
- (e) If Proposer has been convicted of a crime arising from previous public contracts.
- (f) If Proposer is not authorized to perform work in the State of Alaska.

15. Conflict of Interest

Disclose any information that may pose an actual conflict of interest in providing these services or give the appearance of a conflict of interest.

Please provide any other relevant information that may assist ARRC in the selection process.

16. Contract Period

The ARRC anticipates awarding a contract for a three year period, with an option to renew the contract for two additional twelve month periods. Total duration of the contract will not exceed five years.

APPENDIX C

SELECTION PROCESS AND EVALUATION CRITERIA

Alaska Railroad Corporation (ARRC) is requesting proposals from interested firms qualified to perform the work described in the Scope of Services. This is intended to be an unbiased evaluation. ARRC reserves the right to determine that proposed services will meet ARRC requirements. ARRC reserves the right to withdraw this RFP, reject any and all proposals, advertise for new proposals, or accomplish the work by other means including issuing only some of the tasks defined in the Scope of Services above, that ARRC in its sole discretion, determines to be in its best interest.

The selection of a firm to perform the requested services will be made by an ARRC appointed committee which will evaluate the proposals in accordance with the evaluation criteria specified herein and establish a ranking. Proposals will be evaluated on the basis of advantages and disadvantages to ARRC using the criteria described in this Section. Please note, however, that a serious deficiency in any one criterion may be grounds for rejection and that the listing of pricing as an evaluation factor does not require ARRC to select the firm that submits the lowest price. ARRC shall have the right to obtain, from any and all sources, information concerning a Proposer, which is deemed pertinent to the RFP, and to consider such information in the evaluation of the Proposer's proposal.

ARRC reserves the right to select the top ranked firm based solely on the scoring of the written proposals and to enter directly into negotiations with said firm. However, at its sole discretion, ARRC may require the highest ranked firms to make an oral presentation to the evaluation committee. In this event, oral presentations will be scheduled at ARRC's Board Room located at 327 West Ship Creek Avenue, Anchorage, Alaska or through a video conference meeting. The selected firms will have an opportunity to summarize the information provided in their written proposals, expand on their capabilities and experience, and answer questions from the selection committee. Upon completion of the oral presentations, the evaluation committee will review the material presented and determine a ranking order for the firms interviewed in accordance with the evaluation criteria listed herein. Scores obtained in the initial phase will not carry over to the presentation phase. Upon completion of the oral presentations, the evaluation committee will review the material presented and determine a ranking order for the firms interviewed.

Once the committee has established a ranking negotiations will be conducted with the highest ranked firm until a contract is awarded. If an agreement cannot be reached on contract terms, negotiations will be terminated and the next highest ranked firm will be contacted for negotiation. ARRC will release the name of the successful firm upon award of the contract.

Award Criteria for FSA and HSA Administration Services

<u>Criteria</u>	<u>Points</u>
1. Organizational Information	5
2. Implementation	10
3. Customer Service and Communications	15
4. Data System and Web Portal	10
5. Account Administration HAS and FSA	20
6. Plan Documentation Administration and NDT	25
7. Fee Schedule / Fee	15
<u>Total</u>	<u>100</u>

Please complete the Fee Schedule to specify the rates you will charge ARRC for the services under the proposed contract.

Your proposal should contain any detailed fees for the tasks outlined in the scope of services and any ancillary costs associated. Should you need to attach an additional page for this please do so.

Alaska Bidder's Preference:

For the purposes of evaluating price, the proposed price of an offeror who qualifies as an Alaska Bidder shall be reduced by 5%. Offerors seeking an Alaska Bidders Preference must submit information with their proposals documenting that they meet each requirement stated in ARRC Revised Procurement Rule 1200.9(b).

APPENDIX D

VENDOR QUESTIONNAIRE

Note: Failure to provide the information requested in this questionnaire may be cause for rejection of your proposal or offer on the grounds of non-responsiveness and/or non-responsibility.

Solicitation Number _____

Business Name: _____

Street Address: _____

Mailing Address if Different: _____

City: _____ State: _____ Mailing Zip: _____

Telephone: _____ Fax: _____ E-Mail: _____

Date Firm Established: _____

How many years has the business been under the above name? _____

Previous business name(s)if any: _____

Federal Tax ID Number: _____

Business License Number: _____

Bid Acceptance Period _____ Days. (Bids providing less than thirty-day (30) calendar days for acceptance may be considered non-responsive and may be rejected.)

Discount for prompt pay _____ % _____ days.

List any variations from or exceptions to the Terms, Conditions or Specifications of the Solicitation

Continued on the next page

Are you acting as a broker or the primary supplier in this transaction?

- Broker
- Primary Supplier

Business Information (Please check all that apply):

- The business is Individual
- The business is a Partnership
- The business is a Non-Profit
- The business is a Joint-Venture
- The business is a Corporation incorporated under the laws of the State of _____
- The business is full-time
- The business is part-time
- The business is not a certified Disadvantaged Business (DBE)
- Business is a certified DBE
- DBE was certified by State DOTPF
- DBE was certified by the Municipality of Anchorage
- Business is an 8(a)/WBE/MBE and is certified by SBA
- B business was certified by _____
- DBE Certification # is _____

Firms Annual Gross Receipts:

- <\$500,000
- \$500,000 - \$999,999
- \$1,000,000 - \$4,999,999
- \$5,000,000 - \$9,999,999
- \$10,000,000 - \$16,999,999
- >\$17,000,000

Completed by: _____ Title: _____

Signature: _____ Date: _____

APPENDIX E
FEE SCHEDULE

SERVICE	MONTHLY FEE		
	Year 1	Year 2	Year 3
FSA Administration <ul style="list-style-type: none"> • Health Care • Dependent Care • Transit Expenses 			
Debit Cards <ul style="list-style-type: none"> • Initial Card • Additional Card • Duplicate Card 			
Other Administrative Fees: <ul style="list-style-type: none"> • Discrimination Testing • Communication Materials • 800 Number (<i>Specify shared or dedicated</i>) • Postage • Printing of Forms • Travel 			
Other Fees (Specify)			
Total Monthly Fees			
Total Annual Fees			

First Year Set Up Fees

Service	Set Up Fees (Year 1 Only)
Initial Set Up Charge	
Development of Communication Materials (e.g., transition announcement letters, etc.)	
Other (Specify)	
Total Set Up Fees	

Fees and Services

List of all services that are included in fees (Please specify all services as this list will be included in a contract agreement should your firm be selected).

Any special fees, charges or expenses of any kind not included in the base administrative fees.

List of optional services not included in fees, along with associated fees.

HSA Administration			
SERVICE	MONTHLY		
	YEAR 1	YEAR 2	YEAR 3
HSA Administration			
Debit Cards <ul style="list-style-type: none"> • Initial Card • Additional Card • Duplicate Card 			
Other Administrative Fees: <ul style="list-style-type: none"> • Discrimination Testing Communication Materials • 800 Number (<i>Specify shared or dedicated</i>) • Postage • Printing of Forms • Travel 			
Implementation Fees (including any start-up costs)			
List of all services that are included in fees (Please specify all services as this list will be included in a contract agreement should your firm be selected)			
List of optional services not included in fees, along with associated fees			

APPENDIX F

GENERAL TERMS AND CONDITIONS (Professional Service Contracts) (Revised 3/4/08)

The following terms and conditions supersede the terms and conditions on the reverse side of ARRC's purchase order to the extent that they are inconsistent therewith and shall be deemed to have the same force and effect as though expressly stated in any such purchase order into which this document is incorporated.

1. Definitions.

"ARRC" shall mean the Alaska Railroad Corporation.

"Contractor" shall mean the person or entity entering into the contract to perform the work or services specified therein for ARRC.

"Contract" shall mean these General Terms and Conditions, the contract form to which they are annexed, and all other terms, conditions, schedules, appendices or other documents attached to the contract form or incorporated by reference therein.

"Services" shall mean any work, direction of work, technical information, technical consulting or other services, including but not limited to design services, analytical services, consulting services, construction management services, engineering services, quality assurance and other specialized services furnished by Contractor to ARRC under the contract.

2. Inspection and Reports. ARRC may inspect all of the Contractor's facilities and activities under this contract in accordance with the provisions of ARRC Procurement Rule 1600.9. The Contractor shall make progress and other reports in the manner and at the times ARRC reasonably requires.

3. Claims. Any claim by Contractor for additional compensation or equitable adjustment arising under this contract which is not disposed of by mutual agreement must be made by Contractor in accordance with the time limits and procedures specified in sections 1800.12 et seq. of ARRC's Procurement Rules, which by this reference are hereby incorporated herein.

4. Nondiscrimination.

4.1 The Contractor may not discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical or mental handicap, sex, marital status, change in marital status, pregnancy or parenthood when the reasonable demands of the positions do not require distinction on the basis of age, physical handicap, sex, marital status, changes in marital status, pregnancy, or parenthood. To the extent required by law, the Contractor shall take affirmative action to insure that the applicants are considered for employment and that employees are treated during employment without unlawful regard to their race, color, religion, national origin, ancestry, physical or mental handicap, age, sex, marital status, changes in marital status, pregnancy or parenthood. This action must include, but need not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor shall post in conspicuous places, available to employees and applicants for employment, notices setting out the provisions of this paragraph.

4.2 The Contractor shall cooperate fully with ARRC efforts which seek to deal with the problem of unlawful discrimination, and with all other ARRC efforts to guarantee fair employment practices under this contract, and promptly comply with all requests and directions from the State Commission for Human Rights or any of its officers or agents relating to prevention of discriminatory employment practices.

4.3 Full cooperation in Paragraph 4.2 includes, but is not limited to, being a witness in any proceeding involving questions of unlawful discrimination if that is requested by any official or agency of the State of Alaska; permitting employees of the Contractor to be witnesses or complainants in any proceeding involving questions of unlawful discrimination, if that is requested by any official or agency of the State of Alaska; participating in meetings; submitting periodic reports on the equal employment aspects of present and future employment; assisting inspection of the Contractor's facilities; and promptly complying with all State directives considered essential by any office or agency of the State of Alaska to insure compliance with all federal and state laws, regulations, and policies pertaining to the prevention of discriminatory employment practices.

4.4 Failure to perform under this section constitutes a material breach of the contract.

5. Cancellation/Termination.

5.1 ARRC may, for its sole convenience, cancel this contract in whole or in part, at any time by giving written notice of its intention to do so. In the event of such cancellation, Contractor shall be entitled to receive payment in accordance with the payment provisions of this contract for services rendered or charges incurred prior to the effective date of termination. Contractor shall not be paid for any work done after receipt of a notice of cancellation or for any costs incurred by Contractor's suppliers or subcontractors which Contractor could reasonably have avoided. In no event shall ARRC be liable for unabsorbed overhead or anticipatory profit on unperformed services.

5.2 In addition to ARRC's right to cancel this contract for its convenience, ARRC may, by written notice of default to Contractor, terminate the contract in whole or in part in the following circumstances:

(1) The Contractor refuses or fails to perform its obligations under the contract, or fails to make progress so as to significantly endanger timely completion or performance of the contract in accordance with its terms, and Contractor does not cure such default within a period of ten (10) days after receipt of written notice of default from ARRC or within such additional cure period as ARRC may authorize; or

(2) Reasonable grounds for insecurity arise with respect to Contractor's expected performance and Contractor fails to furnish adequate assurance of due performance (including assurance of performance in accordance with the time requirements of the contract) within ten (10) days after receipt of a written request by ARRC for adequate assurance; or

(3) Contractor becomes insolvent or makes an assignment for the benefit of creditors or commits an act of bankruptcy or files or has filed against it a petition in bankruptcy or reorganization proceedings.

5.3 Upon receipt of a notice of cancellation or termination, Contractor shall immediately discontinue all service and it shall immediately cause any of its suppliers or subcontractors to cease such work unless the notice directs otherwise and deliver immediately to ARRC all reports, plans, drawings, specifications, data, summaries or other material and information, whether completed or in process, accumulated by Contractor in performance of the contract. In the event of termination for default, Contractor shall not be entitled to receive any

further payment until the work is finished. If the unpaid balance of the amount to be paid on this contract exceeds the expense of finishing the work, compensation for additional managerial and administrative services and such other costs and damages as ARRC may suffer as a result of Contractor's default, such excess shall be paid to Contractor. If such expense, compensation, costs and damages shall exceed such unpaid balance, Contractor shall be liable for and shall pay the differences to ARRC. The rights and remedies of ARRC provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law.

6. No Assignment or Delegation. The Contractor may not assign, subcontract or delegate this contract, or any part of it, or any right to any of the money to be paid under it, except with the prior written consent of ARRC. The hiring or use of outside services, subcontractors or consultants in connection with the work shall not be permitted without the prior written approval of ARRC. No such approval shall relieve Contractor from any of its obligations or liabilities under this contract.

7. Independent Contractor. The Contractor's relationship to ARRC in performing this contract is that of an independent contractor and nothing herein shall be construed as creating an employer/employee relationship, partnership, joint venture or other business group or concerted action. The personnel performing services under this contract shall at all times be under Contractor's exclusive direction and control and shall be employees of the Contractor, and not of ARRC.

8. Payment of Taxes. As a condition of performance of this contract, the Contractor shall pay all federal, state, and local taxes incurred by the Contractor and shall require their payment by any subcontractor or any other persons in the performance of this contract. Satisfactory performance of this paragraph is a condition precedent to payment by ARRC under this contract.

9. Ownership of Work Product. Except for items that have preexisting copyrights, all exhibits, drawings, plans, specifications, notes, reports, data, recommendations, artwork, memoranda and any other information prepared or furnished by Contractor to ARRC in the performance of this contract (collectively "Work Product") shall become the property of ARRC and may be used by ARRC for any other purpose without additional compensation to the Contractor. Contractor hereby grants ARRC an irrevocable, perpetual, royalty-free, fully assignable license (with full sublicense rights) to use all proprietary and confidential information and other intellectual property that may be incorporated into any of Contractor's Work Product for ARRC. Should ARRC elect to reuse said Work Product, ARRC shall indemnify, hold harmless and defend Contractor and its subcontractors against any damages or liabilities arising from said reuse. When Work Product produced by the Contractor and its Subcontractors under this Contract are reused by ARRC, the Contractor's and Subcontractor's signatures, professional seals, and dates shall be removed. If such Work Product requires professional signature and seal, it will be signed, sealed, and dated by the professional who is in direct supervisory control and responsible for the new project for which such Work Product is being reused.

Contractor hereby represents and warrants to and for the benefit of ARRC and its successors and assigns that no part of its work product for ARRC will infringe any patent rights or copyrights or utilize any proprietary, confidential or trade secret information or other intellectual property for which Contractor does not have the unqualified right to grant ARRC the license and sublicensing rights referred to above. Contractor shall defend, indemnify and hold harmless ARRC, its successors and assigns, and their respective representatives, agents and employees from and against, any and all claims, defenses, obligations and liabilities which they may have or acquire under or with respect to any patent, copyright, trade secret, proprietary or confidential information, or any other form of intellectual property that may be asserted by Contractor or any other person which arises out of, results from or is based upon the manufacture, use or sale by ARRC or any of its successors or assigns of any of Contractor's work product for ARRC. ARRC shall have the

right to select its legal counsel and control its defense in any litigation resulting from any such claim.

10. Governing Law. This contract, and all questions concerning the capacity of the parties, execution, validity (or invalidity) and performance of this contract, shall be interpreted, construed and enforced in all respects in accordance with the laws of the State of Alaska.

11. Alaska Executive Branch Ethics Act Requirements. No officer or employee of the State of Alaska or of the ARRC and no director of the ARRC or legislator of the state shall be admitted to any share or part of this contract or to any benefit that may arise therefrom. Contractor shall exercise reasonable care and diligence to prevent any actions or conditions which could be a violation of Alaska Statute 39.52 et seq. Contractor shall not make or receive any payments, gifts, favors, entertainment, trips, secret commissions, or hidden gratuities for the purpose of securing preferential treatment or action from or to any party. This obligation will apply to the activities of Contractor's employees and agents in their relations with ARRC employees, their families, vendors, subcontractors, and third parties arising from this contract and in accomplishing work hereunder. Certain gratuities may be given or accepted if:

- (1) there is no violation of any law or generally accepted ethical standards;
- (2) the gratuity is given as a courtesy for a courtesy received and does not result in any preferential treatment or action;
- (3) the gratuity is of limited value (less than \$150) and could not be construed as a bribe, payoff or deal; and
- (4) public disclosure would not embarrass ARRC.

ARRC may cancel this contract without penalty or obligation in the event Contractor or its employees violate the provisions of this section.

12. Non-Disclosure of Confidential Information. Contractor acknowledges and agrees that for and during the entire term of this contract, any information, data, figures, projections, estimates, reports and the like received, obtained or generated by Contractor pursuant to the performance of this contract shall be considered and kept as the private, confidential and privileged records of ARRC and will not be divulged to any person, firm, corporation, regulatory agency or any other entity except upon the prior written consent of ARRC. Furthermore, upon termination of this contract, Contractor agrees that it will continue to treat as private, privileged and confidential any information, data, figures, projections, estimates, reports and the like received, obtained or generated by Contractor during the term of the contract and will not release any such information to any person, firm, corporation, regulatory agency or any other entity, either by statement, deposition or as a witness except upon the express written authority of ARRC. ARRC shall be entitled to an injunction by any competent court to enjoin and restrain the unauthorized disclosure of such information.

Contractor's agreement of non-disclosure as specified in this section applies except to the extent required for (1) performance of services under this contract; (2) compliance with professional standards of conduct for preservation of the public safety, health, and welfare (so long as Contractor has given ARRC prior notice of the potential hazard and ARRC has had a reasonable opportunity to correct the hazard prior to disclosure); (3) compliance with a court order or subpoena directed against Contractor (so long as Contractor has given ARRC prior notice of such and ARRC has had an opportunity to contest the same in a court of law); or (4) Contractor's defense against claims arising from performance of services under this contract.

13. Covenant Against Contingent Fees. Contractor warrants that it has not employed or retained any company or person, other than a bona fide employee working solely for Contractor, to solicit or secure this contract, and that it has not paid or agreed to pay any person, company, individual, or firm any commission, gift, percentage, fee, contingent upon or resulting from the award or making of this contract. For the breach or violation of this warranty, ARRC may terminate this contract without liability and, at its discretion, deduct from the contract price or otherwise recover the full amount of the commission, percentage, gift, or fee.

14. Standard of Performance. Contractor shall perform its services with care, skill and diligence in accordance with normally accepted industry standards and shall be responsible for the professional quality, technical accuracy, completeness, and coordination of all reports, designs, drawings, plans, information, specifications and other items and services furnished under this Contract. Contractor shall comply with all applicable federal, state and local laws and ordinances, codes, and regulations in performing its services. If any failure to meet the foregoing standard of performance appears within one (1) year after the services are accepted by ARRC, Contractor shall, at a minimum, reperform the work at no cost to ARRC and shall reimburse ARRC for any additional costs that may be incurred by ARRC or any of its contractors or subcontractors as a result of such substandard work. If Contractor should fail to reperform the work, or if ARRC determines that Contractor will be unable to correct substandard services before the time specified for completion of the project, if any, ARRC may correct such unsatisfactory work itself or by the use of third parties and charge Contractor for the costs thereof. The rights and remedies provided for in this section are in addition to any other remedies provided by law.

15. Warranty. In the event Contractor supplies equipment, goods, materials or other supplies in addition to services under this contract, Contractor warrants that said items: (a) shall be of good quality and free from all defects and deficiencies in workmanship, material and design; (b) shall be fit, suitable and operate successfully for their intended purpose; (c) shall be new; (d) shall be free from all liens, claims, demands, encumbrances and other defects in title; and (e) shall conform to the specifications, if any, stated in the contract. Contractor shall honor all guarantees and warranties offered by the manufacturer of the equipment, goods, materials or other supplies provided under this contract. The rights and remedies provided for in this section are in addition to any other remedies provided by law.

16. Indemnification. Contractor shall defend, indemnify and hold ARRC harmless from and against all claims and actions asserted by a third party (or parties) and related damages, losses and expenses, including attorney's fees, arising out of or resulting from the services performed or neglected to be performed by Contractor or anyone acting under its direction or control or in its behalf in the course of its performance under this contract and caused by any error, omission or negligent act, provided that Contractor's aforesaid indemnity and hold harmless agreement shall not be applicable to any liability based upon the independent negligence of ARRC. If there is a claim of, or liability for, the joint negligent error or omission of the Contractor and the independent negligence of ARRC, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis. The term "independent negligence" is negligence other than ARRC's selection, administration, monitoring, or controlling contractor and in approving or accepting Contractor's work.

17. Insurance. Without limiting Contractor's indemnification, it is agreed that Contractor shall purchase at its own expense and maintain in force at all times during the performance of services under this contract the following policies of insurance. Where specific limits are shown, it is understood that they shall be the minimum acceptable limits. If the Contractor's policy contains higher limits, ARRC shall be entitled to coverage to the extent of such higher limits. Certificates of Insurance must be furnished to the ARRC contracting officer prior to beginning work and must provide for a 30-day prior notice of cancellation, non-renewal or material change. Failure to

furnish satisfactory evidence of insurance or lapse of the policy is a material breach and grounds for termination of the Contractor's services.

17.1 Workers' Compensation Insurance: The Contractor shall provide and maintain, for all employees of the Contractor engaged in work under this contract, worker's compensation insurance as required by applicable law. The Contractor shall be responsible for worker's compensation insurance for any subcontractor who directly or indirectly provides services under this contract. This coverage must include statutory coverage for states in which employees are engaging in work and employer's liability protection not less than \$100,000 per person, \$100,000 per occurrence. Where applicable, coverage for all federal acts (i.e. U.S.L. & H. and Jones Acts) must also be included.

17.2 Comprehensive (Commercial) General Liability Insurance: With coverage limits not less than \$1,000,000 combined single limit per occurrence and annual aggregates where generally applicable and shall include premises-operations, independent contractors, products/completed operations, broad form property damage, blanket contractual and personal injury endorsements. Said policy shall name ARRC as an additional insured and contain a waiver of subrogation against ARRC and its employees.

17.3 Comprehensive Automobile Liability Insurance: Covering all owned, hired and non-owned vehicles with coverage limits not less than \$100,000 per person/\$300,000 per occurrence bodily injury and \$50,000 property damage. Said policy shall name ARRC as an additional insured and contain a waiver of subrogation against ARRC and its employees.

17.4 Professional Liability (E&O) Insurance: Covering all errors, omissions or negligent acts of the Contractor, its subcontractor or anyone directly or indirectly employed by them, made in the performance of this contract which result in financial loss to ARRC. Limits required are per the following schedule:

<u>Contract Amount</u>	<u>Minimum Required Limits</u>
Under \$100,000	\$ 500,000 per Occurrence/Annual Aggregate
\$100,000-\$499,999	\$1,000,000 per Occurrence/Annual Aggregate
\$500,000-\$999,999	\$2,000,000 per Occurrence/Annual Aggregate
Over \$1,000,000	Negotiable-Refer to Risk Management

18. ARRC's Rights Not Waived by Payment. No payment made by ARRC shall be considered as acceptance of satisfactory performance of Contractor's obligations under this contract. Nor shall any payment be construed as acceptance of substandard or defective work or as relieving Contractor from its full responsibility under the contract.

19. Nonwaiver. A party's failure or delay to insist upon strict performance of any of the provisions of this contract, to exercise any rights or remedies provided by this contract or by law, or to notify the other party of any breach of or default under this contract shall not release or relieve the breaching or defaulting party from any of its obligations or warranties under this contract and shall not be deemed a waiver of any right to insist upon strict performance of this contract or any of the rights or remedies as to any subject matter contained herein; nor shall any purported oral modification or rescission of this contract operate as a waiver of any of the provisions of this contract. The rights and remedies set forth in any provision of this Agreement are in addition to any other rights or remedies afforded the nonbreaching or nondefaulting party by any other provisions of this contract, or by law.

20. Savings Clause. If any one or more of the provisions contained in the contract shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality

or unenforceability shall not affect any other provisions of this contract, but this contract shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

21. Headings. The headings of sections and paragraphs of this contract are for convenience of reference only and are not intended to restrict, affect, or be of any weight in the interpretation or construction of the provisions of such sections or paragraphs.

22. Forum Selection. The parties shall not commence or prosecute any suit, proceeding or claim to enforce the provisions of the contract, to recover damages for breach or default under the contract, or otherwise arising under or by reason of the contract, other than in the courts of the State of Alaska for the Third Judicial District at Anchorage. The parties hereby irrevocably consent to the jurisdiction of said courts.

23. Conflict of Interest. Contractor shall act to prevent any actions or conditions which could result in a conflict with ARRC's best interests. This obligation shall apply to the activities of Contractor's employees and agents in their relationships with ARRC's employees, their families, vendors, subcontractors and third parties accomplishing work under this contract.

24. Publicity. Contractor shall not release any information for publication or advertising purposes relative to this contract or to the material, equipment and/or services furnished under this contract without the prior written consent of the ARRC.

25. Audit. ARRC has the right to audit at reasonable times the accounts and books of the Contractor in accordance with the provisions of ARRC Procurement Rule 1600.10.

26. Internal Controls and Record Keeping. Contractor shall keep full and accurate records and accounts of all of its activities in connection with this contract, including, without limitation, reasonable substantiation of all expenses incurred and all property acquired hereunder.

27. Force Majeure. Neither ARRC nor Contractor shall be responsible for failure to perform the terms of this contract when performance is prevented by force majeure, provided that: (1) notice and reasonably detailed particulars are given to the other party and (2) the cause of such failure or omission is remedied so far as possible with reasonable dispatch. The term "force majeure" shall mean acts of God, earthquakes, fire, flood, war, civil disturbances, governmentally imposed rules, regulations or other causes whatsoever, whether similar or dissimilar to the causes herein enumerated, which is not within the reasonable control of either party and which through the exercise of due diligence, a party is unable to foresee or overcome. In no event shall force majeure include normal or reasonably foreseeable or reasonably avoidable operational delays.

28. Permits and Licenses. The Contractor shall, at its own expense, obtain all necessary permits, licenses, certifications and any other similar authorizations required or which may become required by the government of the United States or any state or by any political subdivision of the United States or of any state except where laws, rules or regulations expressly require the ARRC to obtain the same.

29. Environmental Protection. When performing all obligations under the contract, Contractor shall comply with all specific instructions of ARRC with regard to environmental concerns, regardless of whether such instructions are based upon specific law, regulation or order of any governmental authority.

30. Set Off. If ARRC has any claim against the Contractor related or unrelated to this contract, it may set off the amount of such claim against any amount due or becoming due under this contract.

31. Observance of Rules. The contractor's personnel performing work or services hereunder on ARRC's premises shall observe all fire prevention, security, and safety rules in force at the site of the work.

32. No Third-Party Beneficiary Rights. No provision of this contract shall in any way inure to the benefit of any third parties (including the public at large) so as to constitute any such person a third-party beneficiary of the contract or of any one or more of the terms hereof, or otherwise give rise to any cause of action in any person not a party hereto.

33. Entire Agreement. This contract represents the entire and integrated agreement between ARRC and the Contractor and supersedes all prior negotiations, representations, or agreements, either written or oral. This contract may be amended only by a written instrument signed by both ARRC and the Contractor.

34. Key Personnel Changes. Contractor shall secure prior written approval from ARRC for any changes of key personnel assigned to perform services under this contract. ARRC reserves the right to reject any of Contractor's employees whose qualifications and/or experience in ARRC's good faith and reasonable judgment do not meet the standards necessary for the performance of the services required under this contract.

TECHNICAL QUESTIONNAIRE

The purpose of this questionnaire is to provide the Railroad with a basis for determining the Proposer's capability to administer the HSA and FSA programs. The Proposer must be able to perform the services according to the Alaska Railroads Flexible Benefits Plan document and as outlined in this RFP.

All Proposers must respond to the following by restating each question or statement and providing a written response. The Proposer must provide sufficient detail for the evaluation committee to understand how the Proposer will comply with each requirement. If the Proposer believes their qualifications go beyond the minimum standards or add value, the Proposer should indicate how their capabilities exceed the minimum standards.

Fees related to any services specified in the Proposal must be noted only in the Cost Proposal Workbook. Do not include cost/pricing information in any other Section of the Proposal.

ORGANIZATIONAL INFORMATION

1. Is your company authorized to do business in Alaska?
2. Provide a brief narrative about your company.
3. Please describe your organization's accreditations.
4. Provide an organizational chart identifying the names, areas of expertise, functions, and reporting relationships of key people directly responsible for implementing and providing support services for the Railroad.
5. Provide the name of the person with primary responsibility for planning, supervising, and implementing the program for the Railroad plus their bio.
6. Provide the name of the person with primary responsibility for planning, supervising, and performing account management services for the Railroad plus their bio.
7. Describe the role and support by the account manager for the initial roll-out and day-to-day support (i.e., meetings, communications, etc.)
8. Describe how your business model sets you apart from other vendors.

9. What are your organizations' top 3 short term strategic priorities for 2021 and how would they benefit the Railroad?
10. What are your top 3 long-term strategic priorities for the next five years, and how would they benefit the Railroad?
11. Are you willing to serve as claims fiduciary for the programs?
12. Describe your experience in Alaska.
13. How many public sector groups does your organization service? Provide the number of each group and any additional pertinent details.
 - a. Cities, counties or townships
 - b. Universities and/or school districts
 - c. State governments
 - d. Other (please specify)
14. Provide a list of your three (3) largest public sector and (3) largest private sector clients for which your organization currently provides services for the programs you are offering in your Proposal, including:
 - a. Employer name
 - b. The services provided
 - c. The approximate number of participants for each program
 - d. The number of years your organization has provided such services to the employer
15. Please provide three of your employer client references of similar size that will be serving ARRC's employees.

FSA Reference #1

- Company Name
- Contact Person
- Title
- Phone Number
- Fax Number

- Email Address
- FSA Members Enrolled

FSA Reference #2

- Company Name
- Contact Person
- Title
- Phone Number
- Fax Number
- Email Address
- FSA Members Enrolled

FSA Reference #3

- Company Name
- Contact Person
- Title
- Phone Number
- Fax Number
- Email Address
- FSA Members Enrolled

HSA Reference #1

- Company Name
- Contact Person
- Title
- Phone Number
- Fax Number
- Email Address
- HSA Members Enrolled

HSA Reference #2

- Company Name
- Contact Person
- Title
- Phone Number
- Fax Number
- Email Address
- HSA Members Enrolled

HSA Reference #3

- Company Name
- Contact Person
- Title
- Phone Number
- Fax Number
- Email Address
- HSA Members Enrolled Company Name

16. Provide information about the legal/compliance and technical staff who will be available to the Railroad for consultation as needed for program administration.
17. Please restate your agreement that claims and accompanying eligibility data produced in connection with all the claim payment activities on behalf of the Railroad is and will be the property of Railroad and, that the Railroad retains the right to request the full and complete data in electronic format with proper notice at no additional cost.
18. Please restate your agreement that Railroad has the right to audit (or designate an independent third party to audit) the administrator at any time during, and up to two years following termination of the business relationship with prior written notification. The right to audit includes the claims of the Railroad and your organization's contract with the Railroad. The Railroad will not be held responsible for time or miscellaneous

costs incurred by the administrator in association with an audit including, but not limited to, the costs associated with providing audit reports, system access, or space.

19. Please affirm that your company will sign the Railroad's Personal Service Agreement (Exhibit 3).
20. Please confirm that your firm will agree to sign the Railroad's HIPAA Business Associate Agreement (BAA) (Exhibit 4).
21. In the event of a data breach that resulted from a non-ARRC error, would you provide identity theft insurance to plan members?

FEE SCHEDULE / FEES – OTHER FEE QUESTIONS

22. Please confirm that you are in agreement with the guarantee period of 1/1/2021 through 12/31/2024. Fees cannot change except on the contract anniversary date.
23. Confirm that no minimum participation requirement apply to your Proposal.
24. Confirm the ability for authorized ARRC Human Resources representatives to view employee enrollment information.
25. When do fees start to apply for a participant who begins participation mid-year?
26. When do fees cease for a participant who stops participation mid-year?
27. In the event of HSA contract termination, what are your monthly participant fees to process runout claims?
28. The Railroad does not allow direct withdrawals by a vendor from its bank account. Can you accept ACH or Wire transfer initiated by the Railroad?
29. Please confirm your organization's willingness to provide a communication credit to the Railroad in the amount of \$5,000.

IMPLEMENTATION

30. Provide a detailed implementation plan that includes both a project overview and details on specific tasks, timeliness, and responsibilities (open enrollment typically runs from November 15 to December 15 for the January 1, 2021 Plan Year and implementation must be completed at least 60 days prior to open enrollment). Clearly delineate the tasks your organization expects the Railroad to perform and the information you expect the

Railroad and Payroll to provide. Your implementation plan should include, but is not limited, to the following details:

- a. A summary overview of the implementation plan.
- b. A detailed implementation schedule
- c. Include banking and participant account set up details for HSA and FSA.
- d. Points of contact during the implementation.
- e. Major tasks.
- f. Constraints and/or risks.
- g. Data and program set up/configuration process, file verification and validation.
- h. Testing of eligibility files and eligibility logic for HSA, and FSA.
- i. Open enrollment materials development for HSA, and FSA.
- j. Debit card production for HSA, and FSA.
- k. Issue elevation and resolution protocol.

31. Describe the structure of your implementation team. Include the following details:

- a. Identify the implementation manager and provide details regarding their background and experience.
- b. Indicate if the implementation manager will be dedicated to the Railroad for the duration of the implementation. If not, state how many other implementations he/she will support in addition to the Railroad implementation.
- c. Identify any additional key implementation support staff, including those who will be involved in day-to-day implementation work, compliance review, technological support, marketing materials development, training, and employer outreach. Outline the roles and responsibilities for each additional implementation support staff member.
- d. Describe any additional resources available to the Railroad during implementation.
- e. Outline your organization's intended training plan for the Railroad's Human Resources and Payroll staff.

32. Describe in detail what assistance your organization expects from the Railroad in the areas of program design, implementation, and day-to-day administration. Include the anticipated frequency.
33. Please state if your firm will require pre-funding of any of the accounts.

CUSTOMER SERVICE AND COMMUNICATIONS – HSA AND FSA

34. Describe your organization's customer service center hours of operation and location and peak hours of coverage.
 - a. Does your organization provide a dedicated telephone line for clients, or is the same customer service telephone number offered for all clients?
 - b. Describe how your organization handles after-hours member contacts.
35. Describe the information that will be available to participants through your web portal.
36. Provide a sample participant website portal login or color screenshots including details and features.
37. Provide a detailed description of your organization's mobile application for participants and its functionality.
38. Describe how those persons without Internet access or those persons who are not Internet-capable will be able to access the same level of information and services available to those who are able to easily access on the Internet.

For the past year, provide the following:

- a. The total number of inquiries handled by your customer service center.
 - b. The average hold time.
 - c. The abandoned call rate.
 - d. Percent of telephone inquiries resolved during the initial call.
 - e. The total number of email inquiries.
 - f. The average number of days for email inquiry resolution.
 - g. The total number of account accesses from the portal.
39. Do your customer service representatives have access to real-time participant account and claim information?

- a. If so, provide a brief overview of the access (e.g. web portal vs. vendor database, etc.).
- b. If not, explain.

40. Are calls to customer service recorded?

- a. If so, are calls regularly reviewed for quality and performance improvement opportunities?
- b. If so, how often and by whom?
- c. Can a recording be easily accessed in the event of a customer service concern and made available to the Railroad for reference? If not, describe your organization's alternate call quality monitoring processes.

CUSTOMER SERVICE AND COMMUNICATIONS – ENROLLMENT AND ELIGIBILITY – HSA AND FSA

41. Describe your organization's standard annual communication plan for participants. The plan should include a detailed timeline, addressing communications development and delivery, educational outreach, decision-making tools, and enrollment confirmations for participants. Provide pertinent examples of all communications.

- a. List standard communications available to the Railroad at no extra cost.
- b. Provide sample participant guides for each program (HSA and FSA). Indicate how the provided information is made available to participants.
- c. Include details on the method(s) of delivery available for each type of communication (home mailing, email, web portal, etc.)
- d. Describe the Railroad's ability to request custom communications.
- e. Provide sample enrollment guides and welcome brochures for the FSA and HSA programs. Indicate how the provided information is made available to participants.
- f. Provide sample video presentations designed to educate participants on how to use their HSA and FSA.

42. Does your organization require a minimum payroll deduction in order for a participant

to be eligible for a program? If so, detail the applicable program name(s) and deduction amount(s) required based on your Proposal.

43. How often can you accept enrollment files and updates?

44. Does your organization have preferred standard electronic file templates? If so, provide details regarding the file format, and provide a sample for review.

CUSTOMER SERVICE AND COMMUNICATIONS – DEBIT CARD – HSA AND FSA

45. Does your organization offer debit cards to program participants? If yes, provide the following information regarding the company issuing the debit cards:

- a. Vendor name and address.
- b. Telephone number.
- c. Website address.

46. Will participants be automatically issued a debit card for their account(s)?

47. How are the cards activated?

48. Are the debit cards chip-enabled?

49. Provide information on how the debit card may be customized for an employer, including employer branding capabilities (e.g. logo, special colors).

Provide a sample of your standard debit card, including front and back details.

50. Provide sample materials or communications that you provide to employees detailing debit card benefits and functionality (e.g. flyer, brochure, video).

51. Provide the process for recovering overpayments or ineligible claims, including when, how and the nature of communications that are sent to participants on this matter.

52. Provide the following information regarding automatic substantiation:

- a. The types of debit card transactions that would prompt a request for claim substantiation.
- b. A detailed description of all auto-substantiation parameters available.
- c. The methods your organization uses to reduce the number of substantiation requests.

DATA SYSTEM AND WEB PORTAL – HSA AND FSA

53. Describe your organization's previous experience in providing record-keeping, accounting services, and administrative services for clients with a similar number of employees, including electronic transfer via s FTP, virtual private network, encrypted email, and/or paper.
54. The following information should be provided in electronic format:
- a. A specific list, frequency of report generation, and a sample package of standard reports will be provided to the Railroad at no additional charge.
 - b. A detailed description of the process for the Railroad to request additional reports not currently available, and the estimated time of delivery. Additional reporting costs should be included in the Cost Proposal Workbook.
 - c. A sample of a year-end statement sent to the participant showing a participant's account balance.
55. Describe in detail the measures your organization uses to protect the security and privacy of program data, records, forms, participant information, and data processing options.
- a. Include information about the physical security measures used to control access to your organization's systems and internal controls that are in place to reduce the loss that may occur through fraud, negligence, incompetence, or system errors.
 - b. Include information about contingency plans for the continuation of critical business functions during an emergency.
 - c. Indicate whether emergency simulation testing is performed and how often, including the results of the last simulation, if applicable.
 - d. Provide a summary of your organization's disaster recovery plan.
56. Describe abilities available to the railroad and payroll staff to perform the following:
- a. View consolidated accounts.
 - b. View individual participant effective and termination dates.
 - c. View and track individual claim obligations and fulfillment of those obligations.
 - d. View and track individual participant contribution obligations and fulfillment

of those obligations.

- e. Debit card status and settlement report.

ACCOUNT ADMINISTRATION – HSA AND FSA

- 57. Provide details of how your organization accommodates the submission of claims. Include an overview and any pertinent documents for all available methods of reimbursement requests, including submission via a secure web portal, smartphone application, and reimbursement request form.
- 58. Describe how your organization provides for direct deposit of participant reimbursements through Automatic Clearing House (ACH), including the protocols utilized to ensure financial information is protected.
- 59. Please confirm that claims-adjudication will occur at least weekly.
- 60. Describe your HSA banking services or those of the custodian(s) you use. Name the custodian(s) and provide information about your partnership(s) with them.
- 61. Are your HSA offerings FDIC insured?
- 62. How does your system recognize and track HSA beneficiaries?
- 63. Describe the process for a participant to add or change a beneficiary for their HSA. Provide a sample beneficiary designation form.
- 64. Per IRS regulations, the Railroad allows unlimited carryover for the HSA. Describe the annual carryover process for the HSA, including the date carryover funds are available to participants at the start of each Plan Year.
- 65. Indicate if the HSA accepts rollovers/transfers from other HSAs.
- 66. Can your system accept employer contributions? If so, provide any pertinent details regarding system specifications and timing.
- 67. Detail the current investment options available to HSA participants and the associated rate of returns for the past five years. Include the following information:
 - a. Types of fund offerings (e.g. fixed-interest bearing account, money market fund, mutual funds, other).
 - b. Minimum required account balance for investing.
 - c. Provide a copy of any pertinent disclosure statements.

68. Do customer service representatives provide information on investment options?
69. Describe the investment-related educational materials that are available to participants.
In lieu of paper copies, you may provide links to online electronic copies of informational materials.
70. How long has your organization been administering Section 125 plans?
71. How many Section 125 clients does your company currently have?
72. What is your smallest group, based on the eligible population?
73. What is your largest group, based on the eligible population?
74. Please describe your organization's experience in administering plans sponsored by government agencies.
75. How many government agencies does your company currently provide services to?
76. Please describe your organization's experience administering Non-ERISA plans, including:
 - a. Compliance assistance and guidance.
 - b. Reviewing and drafting plan documentation.
 - c. Conducting non-discrimination testing.
77. Indicate your organization's willingness to complete an annual program review. The Railroad would prefer for the review to include overall compliance, for both non-discrimination testing practices and plan documentation, and evaluation for possible recommendations to make the plan more administratively efficient, compliant, participant friendly, and in keeping with industry best practices.
78. Describe any additional, non-standard consultation services that may be made available to the Railroad. Any additional fees should be included in the Cost Proposal Workbook.
79. Can your organization deactivate a participant's debit card if a denied claim is not substantiated? Explain the process.
80. In an instance, when a participant's debit card has been deactivated due to an unsubstantiated claim, can your organization's system automatically reactivate the debit card once the claim is substantiated?

81. Describe your standard process to facilitate claims offset for unsubstantiated debit card transactions.
82. Describe the informational materials that may be developed by your organization to educate participants about substantiation. Provide examples of any pertinent educational materials that may be used to communicate substantiation requirement information to participants.
83. Provide samples of any standard communications sent to Dependent Day Care FSA participants before the end of the Plan Year, reminding them to utilize the remaining funds in their account.
84. Describe your organization's experience with participants mistakenly enrolling in the Dependent Day Care FSA when they meant to enroll in the Health Care FSA, or vice versa. Explain what steps are typically taken to remedy any erroneous account type enrollments
85. How does your system recognize and track qualified relative and dependent eligibility for claims? Describe any criteria or system capabilities you utilize.
86. State if Dependent Day Care FSA expenses can be administered by using the debit card.

PLAN DOCUMENTATION ADMINISTRATION AND NON-DISCRIMINATION TESTING

87. Describe your organization's ability to administer the Railroads plan document (Exhibit 5).
88. Describe your organization's previous experience in developing and maintaining plan documents for Non-ERISA government agencies.
89. Please describe the variety of Section 125 non-discrimination tests your organization provides.
90. Based on the components outlined in the RFP, what non-discrimination tests does your company recommend for the Railroad?
91. Describe your organization's previous experience in performing non-discrimination testing for Non-ERISA government agencies.

92. What information does your organization require from the Railroad in order to conduct non-discrimination testing?
93. Please describe your organization's resolution process in the event of a test failure. Any additional costs should be included in Cost Proposal Workbook.

EXHIBIT 1:

2020 Payroll Schedule

Pay Period	Pay Period Dates	Paid On	
1	12/8/2019-12/21/2019	1/3/2020	
2	12/22/2019-1/4/2020	1/17/2020	
3	1/5/2020 - 1/18/2020	1/31/2020	January
4	1/19/2020 - 2/1/2020	2/14/2020	
5	2/2/2020 - 2/15/2020	2/28/2020	February
6	2/16/2020 - 2/29/2020	3/13/2020	
7	3/1/2020 - 3/14/2020	3/27/2020	March
8	3/15/2020 - 3/28/2020	4/10/2020	
9	3/29/2020 - 4/11/2020	4/24/2020	April
10	4/12/2020 - 4/25/2020	5/8/2020	
11	4/26/2020 - 5/9/2020	5/22/2020	May
12	5/10/2020 - 5/23/2020	6/5/2020	
13	5/24/2020 - 6/6/2020	6/19/2020	June
14	6/7/2020 - 6/20/2020	7/2/2020	
15	6/21/2020 - 7/4/2020	7/17/2020	
16	7/5/2020 - 7/18/2020	7/31/2020	July
17	7/19/2020 - 8/1/2020	8/14/2020	
18	8/2/2020 - 8/15/2020	8/28/2020	August
19	8/16/2020 - 8/29/2020	9/11/2020	
20	8/30/2020 - 9/12/2020	9/25/2020	September
21	9/13/2020 - 9/26/2020	10/9/2020	
22	9/27/2020 - 10/10/2020	10/23/2020	October
23	10/11/2020 - 10/24/2020	11/6/2020	
24	10/25/2020 - 11/7/2020	11/20/2020	November
25	11/8/2020 - 11/21/2020	12/4/2020	
26	11/22/2020 - 12/5/2020	12/18/2020	
27	12/6/2020 - 12/19/2020	12/31/2020	December

EXHIBIT 2

ARRC Contributions For New Year-Around Employees, Employees returning for Seasonal Work, and Employees Returning from Layoff

PP Employee Returns First Payment	% of Year	EE First Payment	EE1 First Payment	FAM First Payment		PP for Second Payment	EE Second Payment	EE1 Second Payment	FAM Second Payment
1	1.00	250.00	500.00	750.00		14	250.00	500.00	750.00
2	0.96	240.38	480.77	721.15		14	240.38	480.77	721.15
3	0.92	230.77	461.54	692.31		15	230.77	461.54	692.31
4	0.88	221.15	442.31	663.46		15	221.15	442.31	663.46
5	0.85	211.54	423.08	634.62		16	211.54	423.08	634.62
6	0.81	201.92	403.85	605.77		16	201.92	403.85	605.77
7	0.77	192.31	384.62	576.92		17	192.31	384.62	576.92
8	0.73	182.69	365.38	548.08		17	182.69	365.38	548.08
9	0.69	173.08	346.15	519.23		18	173.08	346.15	519.23
10	0.65	163.46	326.92	490.38		18	163.46	326.92	490.38
11	0.62	153.85	307.69	461.54		19	153.85	307.69	461.54
12	0.58	144.23	288.46	432.69		19	144.23	288.46	432.69
13	0.54	134.62	269.23	403.85		20	134.62	269.23	403.85
14	0.50	125.00	250.00	375.00		20	125.00	250.00	375.00
15	0.46	115.38	230.77	346.15		21	115.38	230.77	346.15
16	0.42	105.77	211.54	317.31		21	105.77	211.54	317.31
17	0.38	96.15	192.31	288.46		22	96.15	192.31	288.46
18	0.35	86.54	173.08	259.62		22	86.54	173.08	259.62
19	0.31	76.92	153.85	230.77		23	76.92	153.85	230.77
20	0.27	67.31	134.62	201.92		23	67.31	134.62	201.92
21	0.23	57.69	115.38	173.08		24	57.69	115.38	173.08
22	0.19	48.08	96.15	144.23		24	48.08	96.15	144.23
23	0.15	38.46	76.92	115.38		25	38.46	76.92	115.38
24	0.12	28.85	57.69	86.54		25	28.85	57.69	86.54
25	0.08	19.23	38.46	57.69		26	19.23	38.46	57.69
26	0.04	9.62	19.23	28.85		26	9.62	19.23	28.85

EXHIBIT 3
BUSINESS ASSOCIATE AGREEMENT
BETWEEN ABC INC
AND
ALASKA RAILROAD CORPORATION
EFFECTIVE:

This Business Associate Agreement (the "Agreement") shall be entered into by and between ABC, Inc. ("ABC "), and Alaska Railroad (the "Plan Sponsor" and the "Group Health Plan (GHP)") (as defined below). The Agreement shall be effective on the date shown above.

Recitals.

1. In 1996, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"), which required, among other things, the promulgation of privacy rules governing the use and disclosure of protected health information ("PHI") (as defined below), and the protection of electronic protected health information ("EPHI") (as defined below).

In February 2009, Congress enacted the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which amended HIPAA and its implementing regulations codified at 45 CFR Parts 160 and 164.

2. In pertinent part, the implementation regulations for HIPAA, codified at 45 C.F.R. Parts 160, 162 and 164, and as amended (collectively referred to as the "HIPAA Rules") require covered entities, such as the GHP, to maintain a written Agreement with specific provisions concerning PHI and EPHI with its Business Associates (as defined in 45 C.F.R. 160.103 and as amended).
4. ABC has adopted the term "protected personal information" or "PPI" (as defined below) to encompass PHI and the additional information protected by Alaska state and federal privacy laws, which protect personal financial, health and other information (the "Privacy Laws"), and will apply the requirements of the HIPAA privacy rules to PPI.
5. ABC and Alaska Railroad have entered into a Contract for wellness services (the "Contract").

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan Sponsor, the GHP and ABC hereby agree as follows:

1. Definitions. The following definitions shall apply in interpreting this Agreement. Capitalized terms used, but not otherwise defined herein, shall have the same meaning as those terms in the HITECH Act or 45 CFR Parts 160 and 164:
 - 1.1 E PHI. “E PHI” (Electronic Protected Health Information) shall mean any and all PHI transmitted by or maintained in electronic media.
 - 1.2 Group Health Plan or GHP. “GHP” shall be defined consistent with 45 CFR 164.103, and as amended.
 - 1.3 Individual. “Individual” shall mean the person who is the subject of the PPI or their personal representative (as defined in 45 CFR 164.502(g)).
 - 1.4 PHI. “PHI.” (Protected Health Information) shall mean information that meets the requirements in 45 CFR 160.103 or as amended.”
 - 1.5 Protected Personal Information or PPI. “PPI” shall mean PHI and any and all information created or received by ABC from or on behalf of GHP that identifies or can readily be associated with the identity of an Individual, whether oral or recorded in any form or medium, that directly relates to: the past, present or future finances of an Individual, including, without limitation, an Individual’s name, address, telephone number, Social Security Number, subscriber number or wage information.
 - 1.6 Secretary. “Secretary” shall mean the Secretary of the Department of Health and Human Services or his duly appointed designee.
 - 1.7 Security Incident. “Security Incident” shall have the same meaning as the term “security incident” in 45 CFR 164.304, including any subsequent modifications thereto.
2. GHP. ABC and the Plan Sponsor and Alaska Railroad the GHP all agree that the signature of the Plan Sponsor to this Agreement shall be agreed to be the signature of the GHP and binding on behalf of both the Plan Sponsor and the GHP.
3. Permitted Uses and Disclosures of PPI by ABC.
 - 3.1 Functions and Activities on the GHP’s Behalf. ABC shall be permitted to use and disclose PPI for (a) the management, operation and administration of the GHP and (b) as otherwise necessary to provide the services set forth in the Contract, including, but not limited to activities related to Payment and Health Care Operations, including Data Aggregation Services, as defined in 45 CFR 164.501.
 - 3.2 Disclosures to the Plan Sponsor, the GHP or other Business Associates of the GHP. Except as otherwise permitted by written directive from GHP, ABC will not disclose PPI to the Plan Sponsor, the Alaska Railroad, (GHP) or to another business associate of the GHP. ABC may disclose PPI only to those individuals employed by the Alaska Railroad (GHP) or Business Associates of the GHP, including, without limitation, those that the GHP, has identified in writing as individuals to whom PPI can be disclosed. The GHP must provide this written directive to ABC as soon as

possible but in any event no later than the effective date of the Contract. The GHP must promptly notify ABC of any changes to the written directive.

- 3.3 Functions and Activities on ABC 's Behalf. ABC shall be permitted to use PPI as necessary for ABC 's management and administration or to carry out its legal responsibilities as permitted or required by law. ABC shall also be permitted to disclose PPI to its Business Associates, subcontractors or other third parties as necessary for proper management and administration of ABC, or to carry out ABC 's legal responsibilities (a) if the disclosure is required by law or (b) if before the disclosure is made, ABC, obtains a Contract from the entity to which the disclosure is to be made containing reasonable assurances that the entity will also comply with the HIPAA Rules' business associate requirements. ABC will not proceed without notice and discussion with Alaska Railroad.
4. Minimum Necessary. The GHP and the Plan Sponsor will make reasonable efforts to request from ABC only the minimum amount of PPI necessary for its needed purpose. In addition, the GHP and the Plan Sponsor will make reasonable efforts to only disclose to ABC the minimum amount of PPI necessary for ABC to perform the services identified in the Contract and other functions and activities referenced in Section 3 of this Agreement. Finally, ABC will make reasonable efforts to use, disclose, or request only the minimum amount of PPI necessary from any third party to perform the services identified in the Contract and other functions and activities Ireferenced in Section 3 of this Agreement. When feasible, as determined by the party maintaining PPI, the parties shall create, use or disclose a Limited Data Set.
5. Other Privacy Obligations of ABC. ABC shall:
 - 5.1 Not use or further disclose PPI other than as permitted or required by the Contract, the Agreement, the HIPAA Rules or Privacy Laws and use appropriate safeguards to prevent any unauthorized use or disclosure of PPI;
 - 5.2 Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the EPHI that ABC creates, receives, maintains, or transmits on behalf of theGHP;
 - 5.3 Report to GHP any actual use or disclosure of PPI concerning GHP's members not permitted or required by the Contract, the Agreement or law of which it becomes aware;
 - 5.4 Notify the GHP of any Security Incident of which it becomes aware; provided, however, the obligation to report a Security Incident shall not include immaterial incidents, such as unsuccessful attempts to penetrate ABC 's information systems.
 - 5.5 Ensure that any agents, including a subcontractor, to whom it provides PPI and/or EPHI received from, or created, received or maintained by ABC on behalf of, the GHP, agree in writing to the same restrictions, conditions and requirements as outlined in the HIPAA Rules that apply to a Business Associate with respect to such information.

- 5.6 Make available PPI in a Designated Record Set, in either paper or electronic format, as required by 45 CFR 164.524;
 - 5.7 Make available PPI for amendment and incorporate any amendments to PPI as required by 45 CFR 164.526;
 - 5.8 Make available the information required to provide an accounting of disclosures as required by 45 CFR 164.528;
 - 5.9 Make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PPI or PHI and/or the protection of EPHI received from, or created or received by ABC on behalf of, the GHP available to the Secretary for purposes of determining the GHP's compliance with the HIPAA Rules, including documentation sufficient to meet the administrative requirements of 45 CFR §164.414 for breach notifications described in subsection 5.11, below;
 - 5.10 Restrict the use and disclosure of PPI in accordance with 45 CFR 164.522 and consistent with ABC's policies, procedures and practices;
 - 5.11 Report promptly information to the GHP about any use or disclosure of Unsecured PHI of the GHP's members not permitted or required by the Contract, the Agreement, or law caused by ABC or one of its subcontractors for which it becomes aware and that ABC determines Compromises the Security or Privacy of the PHI (collectively referred to as a "ABC Breach");
 - 5.12 Notify, or direct its subcontractor to notify, an Individual as required by 45 CFR §164.404, the media as required by 45 CFR §164.406 and the Secretary as required by §164.408(b), for a ABC Breach reported to the GHP under subsection 5.11 above;
 - 5.13 Provide the GHP with the information necessary about any ABC Breach in order for the GHP to include such information in the GHP's log of Breaches that must be filed annually with the Secretary as required by 45 CFR §164.408(c);
 - 5.14 Comply with the following HIPAA provisions: Subpart C of 45 CFR Part 164, and Business Associate requirements (45 CFR §164.502(e)(2) and 45 CFR §164.504(e)); and
 - 5.15 Comply with Accounting for Disclosure (45 CFR §164.528) in the event that Department of Health and Human Services rules clarify that the GHP has one or more Electronic Health Records that ABC creates, accesses, uses or maintains.
6. ABC's Privacy-Related Services Regarding Requests by Individuals. Upon receipt, the GHP shall immediately provide notice to and forward any and all individual requests received pursuant to 45 CFR Sections 164.522, 164.524, 164.526 or 164.528 of the HIPAA Rules (collectively referred to as the "Requests") consistent with Exhibit D-1. Upon ABC's receipt of the Requests, either from the GHP or directly from the Individual, ABC shall:
- 6.1 Evaluate each request consistent with the HIPAA Rules and ABC's policies, procedures and practices;

- 6.2 For Requests that may affect the policies, procedures or practices of the GHP, coordinate with the GHP about evaluation of the Requests and mutually agree on the result;
- 6.3 For Requests that may involve the GHP's other Business Associates, request information from the Business Associates identified by the GHP necessary for fulfilling the Requests;
- 6.4 Communicate the result of the evaluation directly to the Individual within the legal timeframes established for each type of request; and
- 6.5 Notify the GHP of the outcome of each Request identified by the GHP at the time of notice to ABC; and
- 6.6 Implement each Request that is granted.

Such services shall be included in ABC's Administration Fee set forth in Attachment C in the Contract.

7. Obligations of GHP.

- 7.1 Requests by GHP. Neither GHP nor the Plan Sponsor shall request ABC to use, disclose or maintain PPI in any manner that would not be permissible under HIPAA if done directly by GHP.

8. Term and Termination.

- 8.1 Term. The Term of this Agreement shall begin as of the Effective Date contained herein and shall remain in effect for the duration of the Contract, including any runout period required under the Contract. This Agreement shall automatically renew for the additional terms of any Contract renewal or subsequent Administrative Services Contract between ABC and the Plan Sponsor.
- 8.2 Termination for Breach of Privacy Obligations. Either Party shall have the right to terminate the Contract as outlined in the Contract if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of its obligations regarding PPI under this Agreement, the Contract or law.
- 8.3 Effect of Termination.
 - a. Return or Destruction of PPI Upon Termination of Contract. Upon cancellation, termination, expiration or other conclusion of the Contract, ABC will, if feasible, return to the GHP or else destroy PPI, in whatever form or medium that ABC, created or received for or from the GHP, including all copies of and any data or compilations derived from such PPI that allow identification of any Individual. ABC will complete such return or destruction as promptly as practical, but not later than sixty days after the effective date of the cancellation, termination, expiration or other conclusion of the Contract.
 - b. Reimbursement. The Plan Sponsor will reimburse ABC's reasonable costs and expenses incurred in returning or destroying such PPI.

c. Disposition When Return or Destruction of PPI Is Not Feasible. In the event that returning or destroying the PPI is not feasible as determined by ABC, ABC will limit further use or disclosure of the PPI to those purposes that make their return to the GHP or destruction infeasible and shall extend the privacy protections contained herein to that PPI for as long as ABC retains it.

9. Order of Precedence. This Agreement shall supersede and replace any and all provisions in the Contract concerning confidentiality or privacy of PPI. In addition, the notice provisions of this Agreement shall prevail over the Contract only to the extent that such notice is related to the obligations contained herein. Except as otherwise provided in this section, in the event that any other terms or conditions contained in this Agreement conflict or are inconsistent with the Contract, the terms and conditions of the Contract shall prevail.

IN WITNESS WHEREOF, the parties have signed this Agreement effective as of the date indicated above.

ABC

Its:

Date:

ALASKA RAILROAD, PLAN SPONSOR AND GROUP HEALTH PLAN (GHP)

Its:

Date:

EXHIBIT 4

**ALASKA RAILROAD CORPORATION
FLEXIBLE BENEFIT PLAN**

2020 Restatement

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Appendix A- PLAN PROVISIONS APPLICABLE TO EMPLOYEES COVERED UNDER A COLLECTIVE BARGAINING AGREEMENT

ALASKA RAILROAD CORPORATION FLEXIBLE BENEFIT PLAN

INTRODUCTION

Alaska Railroad Corporation (Employer) has restated this Flexible Benefit Plan effective January 1, 2020. Its purpose is to provide benefits for eligible Employees. The Plan allows Employees to choose among different types of pre-tax benefits based on their own particular goals, desires and needs, including the ability to pay certain contributions or premiums on a pre-tax basis. The Plan's name is the Alaska Railroad Corporation Flexible Benefit Plan (the "Plan").

The Employer intends that the Plan qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

The Health Flexible Spending Account Plan (HFSA Plan), a Component Plan of the Plan, is intended to qualify as a "self-insured medical reimbursement plan" under Code Section 105, and the Qualifying Medical Care Expenses reimbursed by it are intended to be eligible for exclusion from participating employees' gross income under Code Section 105(b).

The Dependent Care Flexible Spending Account Plan (DCFSA Plan) a Component Plan of the Plan, is intended to qualify as a "dependent care assistance plan" under Code Section 129, and the Qualifying Dependent Care Expenses reimbursed by it are intended to be eligible for exclusion from participating employees' gross income under Code Section 129(a).

The Plan allows eligible employees to make voluntary contributions to their Health Savings Accounts through this Plan, but the Health Savings Accounts are individual accounts and not plans sponsored by the Employer. The Plan also provides Health Savings Account benefits under the Plan.

Although all are reprinted in this document, the HFSA Plan and the DCFSA Plan are separate plans for purposes of administration and all applicable reporting and nondiscrimination requirements imposed by Code Sections 105 and 129, and the HFSA Plan is a separate plan for purposes of complying with COBRA, HIPAA, and other applicable laws.

ARTICLE I DEFINITIONS

1.1. “Administrator” or “Plan Administrator” means the Employer unless another person or entity has been designated by the Employer pursuant to Section 10.1 to administer the Plan on behalf of the Employer. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

“Annual Open Enrollment Period” means a period of time prior to the commencement of the Plan Year during which a Participant may elect coverage under the Plan or a Participant may change elections under the Plan for the following Plan Year. The Annual Open Enrollment Period is set by the Employer.

“Cause” means fraud or material misrepresentation on the Plan or Component Plan by a Participant, or by a member of a Participant’s family, or by another person acting for or on behalf of a Participant. This may include, but is not limited to, an act or omission committed by a person who, knowingly, and with intent to defraud, commits one or more of the following:

- (a) presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to the Plan or Component Plan, false information as part of, in support of, or concerning a fact material relating to one or more of the following:
 - (i) a form or application to enroll in the Plan or Component Plan;
 - (ii) a claim for payment or benefit pursuant to the Plan or a Component Plan;
 - (iii) premiums or contributions paid for benefits or coverage under the Plan or a Component Plan;
 - (iv) payments made in accordance with the terms of the Plan or a Component Plan; or
 - (v) the reinstatement of coverage under the Plan or a Component Plan.
- (b) concealing any material information from the Plan or a Component Plan;
- (c) failure to provide proof to the Plan Administrator that a family member qualifies or continues to qualify as a Dependent under the Plan;
- (d) enrolling a person in the Plan or a Component Plan who is not eligible for the Plan or a Component Plan or failing to disenroll a person who is not eligible for the Plan or a Component Plan; or
- (e) willful embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits, or other property of the Plan or a Component Plan; or
- (f) attempting to commit or aiding or abetting in the commission of the acts or omissions specified herein.

“Change Event” means any of the events described in Treasury Regulation 26 C.F.R. § 1.125-4.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended, as applicable to this Plan and including all applicable COBRA regulations.

“COBRA Continuation Coverage” means continued health coverage which is available in certain situations where coverage would otherwise cease, in accordance with COBRA.

“Code” means the Internal Revenue Code of 1986, as amended or replaced from time to time, including all applicable Treasury regulations.

“Compensation” means the regular salary or wages paid to a Participant by the Employer for services rendered during the portion of the Plan Year that the Participant is eligible to participate in this Plan. However, Compensation shall not include amounts which are (1) received by any person in a capacity as a consultant, director or independent contractor; (2) paid to a Participant by the Employer as reimbursement for expenses incurred by the Participant or similar non-wage payments; (3) excluded from an Participant’s Compensation due to a Participant’s contribution to an employee benefit plan which is not a Component Plan under Section 4.1, including, but not limited to, the 457, 401(k) and pension plans sponsored by the Employer.

“Compensation Reduction Amounts” means amounts which the Participants elect to contribute to the Flexible Spending Accounts each Plan Year pursuant to Section 3.1, amounts which the Participants enrolled in the Medical and/or Dental Plans are required to contribute to the Premium Payment Plan; and premium amounts for the first \$50,000 of coverage under the Life Insurance Plan. For the FSA Plans, these contributions are allocated to the FSA Plan Accounts established under the DCFSA Plan or HFSA Plan, as directed by the Participants, pursuant to the Participants' elections made under Article V.

“Compensation Reduction Agreement” means an agreement between the Participant and the Employer under which the Participant agrees to reduce the Participant’s Compensation and to have such amounts credited to the FSA Plans or to the Participant’s HSA (for HSA-Eligible Individuals) on the Participant’s behalf. The Compensation Reduction Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant. This term also includes HSA Contribution Amounts elected by Participants who are HSA-Eligible Individuals.

“Component Plan” means one or more of the following component plans of this Plan:

- (a) the Premium Payment Plan;
- (b) the HFSA Plan; or
- (c) the DCFSA Plan.

“Dental Plan” means a dental plan sponsored by the Employer.

“Dependent” means Dependent Spouse or Dependent Child, subject to further limitations set forth in the Component Plans, with respect to coverage under each Component Plan. The Plan Administrator may require proof that a person qualifies as a Dependent under the Plan or any

Component Plan, and may deny dependency status or eligibility if a Participant does not provide such proof. For example, a Participant may be requested to provide:

- (a) A copy of a marriage license;
- (b) A copy of a child's birth certificate, adoption decree, or court order granting guardianship.

For purposes of a Health Savings Account, the term "Dependent" has the meaning given it by Code Section 223.

"Dependent Care Reimbursement Account" means the account described in Section 7.3.

"Dependent Care Flexible Spending Account Plan" or "DCFSA Plan" means the Component Plan set forth in Article VII.

"Dependent Child" means any child who is the dependent of the Participant as defined in Code Section 152 (determined without regard to Code Sections 152(b)(1), 152(b)(2) and 152(d)(1)(B)), subject to further limitations in any Component Plan. For purposes of Medical and Dental Plan coverage funded through the Premium Payment Plan, any child to whom Code Section 152(e) applies is treated as a dependent of both parents. Notwithstanding the foregoing, a child for whom the Participant is required by a judgment, decree or order issued by a court or through an administrative process established under state law to provide medical coverage shall be a Dependent Child for purposes of the Health Flexible Spending Account Plan and the Medical and Dental Plans funded through the Premium Payment Plan. For purposes of these same plans, Dependent Child also includes the following children through the end of the month in which they turn age 26: (1) a Participant's son, daughter, stepson, or stepdaughter, including children legally adopted by the Participant or placed with the Participant for legal adoption; and (2) a foster child, a child placed with the Participant under legal guardianship, or a child otherwise placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

For purposes of the Dependent Care Flexible Spending Account Plan, a Dependent Child means a Qualifying Dependent who is a child, and in the case of divorced parents, the Dependent Child shall, as provided in Code Section 21(e)(5), be treated as a Qualifying Dependent of the custodial parent (within the meaning of Code Section 152(e)(3)(A)) and shall not be treated as a Qualifying Dependent with respect to the non-custodial parent.

"Dependent Spouse" means an individual who is legally married to a Participant. Notwithstanding the foregoing, for purposes of the Dependent Care Flexible Spending Account Plan, the terms "Dependent Spouse" and "Qualifying Dependent" shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal place of residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Eligible Employee" means any regular full-time or regular part-time Employee, other than a leased employee or Special Services Employee. Notwithstanding the foregoing, members of a collective bargaining unit shall not be eligible to participate in the Plan unless provided pursuant

to a collective bargaining agreement and subject to the terms in Appendix A. Other classes of Employees may be added or excluded by resolution of the Board of Directors of the Employer.

“Employee” means any person who is employed by the Employer. The term shall not include leased employees within the meaning of Code Section 414(n)(2). The term also does not include any individual who is not reported on the payroll records of the Employer as a common law employee. These persons are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

“Employer” means the Alaska Railroad Corporation.

“Flexible Spending Account Plans” or “FSA Plans” means the DCFSA Plan and the HFSA Plan.

“FMLA” means the Family and Medical Leave Act of 1993, as amended, and including all applicable FMLA regulations.

“Full Contribution Rule” means that a Participant who is an HSA-Eligible Individual on December 1 of any calendar year shall be treated as having been an HSA-Eligible Individual during each of the months in the calendar year, but only for purposes of calculating the amount of contributions that can be made to the Participant’s HSA for that calendar year and not for purposes of determining when the Participant’s HSA is established or the amount of the Employer HSA Benefits.

“Grace Period” means the two and one-half month period immediately following the end of each Play Year, beginning on January 1 and ending on March 15. The Grace Period relates to the immediately preceding Plan Year. The Grace Period only applies to the Health Flexible **Spending Account Plan and the Dependent Care Flexible Spending Account Plan.**

“Health Savings Account” or “HSA” means an individual trust or custodial account separately established by a Participant with a qualified trustee or custodian under Code Section 223.

“High Deductible Health Plan” or “HDHP” means the high deductible health plan option(s) offered under the Medical Plan sponsored by the Employer that is intended to qualify as a high deductible health plan under Code Section 223(c)(2).

“Health Flexible Spending Account” means the account described in Section 6.4.

“Health Flexible Spending Account Plan” or “HFSA Plan” means the Component Plan set forth in Article VI.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended, and the applicable HIPAA regulations.

“HSA Benefits” means the HSA Contributions that a Participant has elected to make through a Compensation Reduction Agreement, plus any contributions which the Employer may make to the HSA through this Plan from time-to-time (“Employer HSA Benefits”).

“HSA Contributions” means the contribution amount elected by the Participant to contribute to the Participant’s HSA under a Compensation Reduction Agreement. In no event shall the amount elected exceed the statutory maximum amount for HSA Contributions applicable to the Participant’s High Deductible Health Plan coverage for the calendar year in which the HSA

Contribution is made. The maximum HSA Contribution shall be: (a) reduced by any Employer HSA Benefits; and (b) unless the Full Contribution Rule applies, prorated for the number of months in which a Participant is an HSA-Eligible Individual.

“HSA-Eligible Individual” means a Participant who elects the High Deductible Health Plan and who is otherwise eligible to contribute to an HSA under the Code, determined as of the 1st day of each month.

“Life Insurance Plan” means the life insurance plan sponsored by the Employer.

“Loss of Coverage” means a complete loss of coverage under, or elimination of, a Component Plan or a Medical or Dental Plan, including the elimination of a Component Plan. In addition, the Plan Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a loss of coverage:

- (a) a substantial decrease in the medical or dental care providers available under a Component Plan or Medical or Dental Plan;
- (b) a reduction in benefits for a specific type of medical or dental condition or treatment with respect to which the Participant or the Participant’s Dependents are currently in a course of treatment; or
- (c) any other similar fundamental loss of coverage.

“Medical Plan” means the medical plan or plans sponsored by the Employer providing medical benefits.

“Participant” means any Employee who is a Participant pursuant to Section 2.1 and has not for any reason become ineligible to participate further in the Plan.

“Plan” means the Alaska Railroad Corporation Flexible Benefit Plan.

“Plan Year” means the 12-month period beginning January 1 and ending December 31.

“Premium Expenses” or “Premiums” mean the Participant’s cost for Medical, Dental and/or Life Insurance Plan which is allowed to be paid through the Premium Payment Plan.

“Premium Payment Plan” means the Component Plan set forth in Article VIII, the sole benefit of which is to pay certain premiums for the Medical Plan, Dental Plan and/or Life Insurance Plan on a pre-tax basis.

“Protected Health Information” or “PHI” means any information created or received by the HFSA Plan that relates to:

- (a) a Participant’s or Dependent’s past, present, or future physical or mental health or past, present, or future physical or mental condition;
- (b) the provision of health care to a Participant or Dependent; or
- (c) the past, present, or future payment for health care.

“Special Services Employee” shall mean any employee hired for a specific length of time who is notified that the job will not be permanent at the beginning of employment. Special Services Employees may be hired part-time or full-time.

“Spouse” means the legally married spouse of a Participant.

ARTICLE II PARTICIPATION

2.1 INITIAL ELIGIBILITY

Any Employee shall automatically become a Participant in this Plan as of the first date of the Employee's payroll period after the Employee becomes an Eligible Employee. No Eligible Employee is allowed to elect not to participate in the Plan. However, a Participant may elect not to participate in a Component Plan or contribute to an HSA. A Participant's right to participate in a Component Plan or contribute to an HSA is dependent upon the Participant's satisfying the specific terms and conditions or participation applicable to the Component Plan or HSA.

2.2 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.3;
- (b) **Death.** The Participant's death, subject to the provisions of Section 2.3; or
- (c) **Cessation of Eligibility,** The day the Participant ceases to be an Eligible Employee.
- (d) **Termination of the Plan.** The termination of this Plan.
- (e) **Termination for Cause.** The termination of the Participant's participation by the Employer for Cause.

Any fees or other charges imposed by the HSA custodian or trustee regarding the individual's or Participant's HSA shall be the sole responsibility of the individual or Participant, and shall not be an expense of the Plan, the Plan Administrator or the Employer when: (1) imposed after the individual's or Participant's participation in the Plan has ceased; or (2) imposed after the Participant is no longer participating in the High Deductible Health Plan.

2.3 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason or the Participant dies, the Participant's participation in the Component Plans provided under Section 4.1 shall be governed in accordance with the following:

- (a) **Premium Payment Plan.** The Participant's right to pay the contributions on a pre-tax basis under the Premium Payment Plan shall cease after the final paycheck of the Employer to the Participant.
- (b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Compensation Reduction Amounts or other contributions to the DCFSA Plan shall be made or accepted after the final paycheck of the Employer to the Participant. However, to the extent that such Participant has a balance in the Participant's Dependent Care FSA Account as of the date of termination, such Participant may submit claims for eligible Employment-Related Dependent Care Expense reimbursements for claims incurred prior to termination or incurred through the

remainder of the Plan Year and applicable Grace Period in which such termination occurs, until the Participant's Dependent Care FSA Account is zero. These claims must be submitted within 120 days of the end of the Plan Year in which the termination of employment occurred.

(c) **Health FSA.** With regard to the Health Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Compensation Reduction Amounts or other contributions to the Plan shall be made or accepted, except that (1) the Participant may submit claims for Qualifying Medical Expenses that were incurred during the portion of the Plan Year before termination; and (2) the Participant (and other Qualified Beneficiaries) may continue participation for the remainder of the Plan Year and applicable Grace Period if eligible to do so under the provisions of COBRA. A Participant has 90 days following the earliest of (a) the last day of the Plan Year, (b) the last day of the month in which the Participant terminates employment, or (c) the last day of the month in which the Participant ceases to be an Eligible Employee, to submit claims for reimbursement for health care expenses incurred during the Plan Year but prior to termination of employment. Any amounts still credited to the Participant's Health Flexible Spending Account(s) after that 90 day period expires shall be forfeited and remain the assets of the Employer.

(d) **Death.** If a Participant dies, the Participant's Dependents, or the legal representative of the Participant's estate may submit claims and otherwise act on behalf of the Participant and may receive benefit payments to the DCFSA and/or HFSA that would otherwise be payable to the Participant. However, such Participant's beneficiaries, or the representative of the Participant's estate, may only submit claims relating to the deceased Participant's participation in the DCFSA or the HFSA incurred prior to death if submitted within 120 days of the end of the Plan Year. Unless the Administrator has been informed to the contrary by the Participant prior to the Participant's death, the Administrator may designate the Participant's Spouse, one of the Participant's Dependents or a representative of the Participant's estate for this purpose.

(e) **Employer HSA Benefits.** The Participant shall receive no further Employer HSA Benefits.

2.4 TERMINATION OF HSA ELIGIBILITY

Once a Participant is no longer an HSA-Eligible Individual, no further HSA Benefits will be provided by this Plan.

ARTICLE III CONTRIBUTIONS TO THE PLAN

3.1 CONTRIBUTIONS/COMPENSATION REDUCTION AMOUNTS

Benefits under the Flexible Spending Account Plans and the HSA Contributions shall be financed by Compensation Reduction Amounts elected by Participants for each FSA Plan and/or HSA. The Compensation Reduction Amounts shall be specified in the Compensation Reduction Agreement and shall be applicable for a Plan Year. The contributions to the Flexible Spending Account Plans shall be allocated to the Accounts established under the Flexible Spending Account Plans pursuant to the Participants' elections made under Article V.

3.2 APPLICATION OF CONTRIBUTIONS TO FSA PLANS

As soon as reasonably practical after each payroll period, the Employer shall apply the Compensation Reduction Amounts to provide benefits under to the Component Plans as elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such Accounts.

3.3 SPECIAL RULES FOR CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS

Participants in this Plan who are also participating in the High Deductible Health Plan and who are otherwise HSA-Eligible Individuals may elect to reduce their Compensation and have such amounts contributed to their Health Savings Accounts in accordance with the following rules:

(a) Participants may not make contributions to their Health Savings Accounts under this Plan that together with the Employer HSA Benefits exceed the limits set forth in Code Section 223.

(b) Participants may change their elections regarding such contributions at any time during the Plan Year. However, such changes will not be effective until on the first day of the payroll period following the date the election change has been processed by the Plan Administrator.

ARTICLE IV COMPONENT PLANS

4.1 COMPONENT PLANS

Each Participant may elect to enroll one or both of the following optional Component Plans:

(1) Health Flexible Spending Account Plan. If enrolled, Article VI shall apply. Participants enrolled in a high deductible medical plan option under the Medical Plan are not eligible for this Plan.

(2) Dependent Care Flexible Spending Account Plan. If enrolled, Article VII shall apply.

A Participant in the High Deductible Plan who is an HSA-Eligible Individual (1) may elect to have a reduction in Compensation applied as a contribution to the Participant's HSA as provided in Article III of this Plan; and (2) is eligible for the Employer HSA Benefits, if any. Employer HSA Benefits, if any, are communicated to Participants prior to or during the annual Enrollment Period which precedes such Plan Year.

If a Participant elects to participate in the Medical, Dental and/or Life Insurance Plan, the Participant is required to participate in the Premium Payment Plan. Such Participant shall be deemed to have elected to have the Participant's Compensation reduced in the amount of the required contributions for the Participant for (1) the Medical and/or Dental Plan; and (2) the first \$50,000 in coverage under the Life Insurance Plan, and paid by the Premium Payment Plan on a pre-tax basis.

4.2 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of Employees which the U.S. Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 125, the Administrator may, but shall not be required to, reject any election or reduce contributions or non-taxable benefits in order to assure compliance with this Section, or take any other actions necessary to avoid any such discrimination. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable benefits, it may be done in the following manner. First, the non-taxable benefits of the affected Participant who has the highest amount of non-taxable benefits for the Plan Year shall have the Participant's non-taxable benefits reduced, until the discrimination tests set forth in this Section are satisfied or until the amount of the Participant's non-taxable benefits equals the non-taxable benefits of the affected Participant who has the second highest amount of non-taxable benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Plan benefits and Dependent Care Flexible Spending Account Plan benefits, and once all these benefits are expended, to the contributions to the Medical Plan. Contributions which are not utilized to provide benefits to any

Participant by virtue of any administrative act under this paragraph shall be forfeited and used by the Plan like other forfeitures.

ARTICLE V PARTICIPANT ELECTIONS

5.1 INITIAL ELECTION

An Employee who meets the eligibility requirements of Section 2.1 automatically becomes a Participant in the Plan, as of the first day the Employee is eligible for coverage under the Plan. A Participant must make the initial election to participate in the Component Plans within 31 days of first being eligible to participate in the Plan, which election shall remain in effect until the end of the Plan Year and any applicable Grace Period unless the Participant is entitled to change the Participant's Benefit elections pursuant to Section 5.4 hereof.

However, no separate election is allowed or required for the Premium Payment Plan: if the Participant is enrolled in the Medical, Dental and/or Life Insurance Plan, the Participant automatically is enrolled in the Premium Payment Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

A Participant wishing to receive Flexible Spending Account Plan benefits must complete an election form and a Compensation Reduction Agreement each year during the Annual Open Enrollment Period. The election made on such form shall be irrevocable until the end of the applicable Plan Year and applicable Grace Period unless the Participant is entitled to change the Participant's Benefit elections pursuant to Section 5.4 hereof.

5.3 FAILURE TO COMPLETE ELECTION FORMS DURING ANNUAL OPEN ENROLLMENT PERIOD

If a Participant fails to complete an election form and/or Compensation Reduction Agreement during the Annual Open Enrollment Period: the Participant (1) shall not receive any benefits under either FSA Plan during the following Plan Year, unless the Participant has a Change Event as described in Section 5.4; (2) shall be deemed to have elected to continue to make the same HSA contributions in the following Plan Year as in the current Plan Year, the Participant is no longer eligible to make HSA Contributions; and (3) shall be deemed to have elected to participate for the following Plan Year in the Medical, Dental and/or Life Insurance Plan in which the Participant was participating in the current Plan Year.

5.4 CHANGE EVENTS

Except for changes to HSA Contributions, which are governed by Section 3.3 of this Plan and not this Section 5.4, a Participant may not change the Participant's elections during a Plan Year except as provided in this Section 5.4. Participants wishing to change their elections must complete and submit a new election form within 30 days of the Change of Status event, except new election forms may be submitted within 60 days of certain HIPAA Special Enrollment Change Events to the extent permissible under HIPAA. However, no changes relating to the previous Plan Year may be made during the Grace Period.

A Participant may change an election as described below upon the occurrence of an event described below, so long as the elections are made in accordance with the election procedures of the Plan and the election changes meet the required consistency rules of Treasury Regulation 26 C.F.R. Section 1.125-4.

(a) **Change Events.** This provision applies to Premium Payment Plan and the Flexible Spending Account Plans, as limited below. A Participant may change the Participant's election or deemed election under the Plan upon the occurrence of a Change Event provided: (1) such Change Event affects eligibility for coverage under a plan of the Employer or a plan of the Dependent's employer (referred to as the "general consistency requirement"); and (2) the

election change is made on account of and corresponds with such Change Event. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on applicable law, whether a requested change meets these requirements. In addition to satisfying the general consistency requirement, Change Event may have to meet certain specific consistency requirements set forth as set forth below or as provided in the Treasury regulations.

(1) **Loss of Dependent's Eligibility; Special COBRA Rule.** If the Change Event is the Participant's divorce or annulment from the Participant's Dependent Spouse, the death of a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may revoke or cancel coverage under the Premium Payment Plan relating to the coverage under the Medical and/or Dental Plans only for: (1) the Dependent Spouse involved in the divorce or annulment; (2) the deceased Dependent; or (3) the Dependent who ceased to satisfy the eligibility requirements.

(2) **New Coverage Eligibility Under Another Employer's Plan.** For a Change Event in which a Participant or the Participant's Dependent gains eligibility for coverage under a cafeteria plan or other benefit plan of the employer of the Participant's Dependent as a result of a change in marital status or employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Dependent's employer's plan.

(3) **FMLA and Non-FMLA Leaves of Absence.** This provision applies to all Component Plans. A Participant may change the Participant's election under the Plan upon an unpaid or paid FMLA leave of absence in accordance with Section 5.7 and upon an unpaid non-FMLA leave of absence in accordance with Section 5.7.

(b) **HIPAA Special Enrollment Rights**

This provision applies only to coverage under the Medical and Dental Plans funded through the Premium Payment Plan. If a Participant or the Participant's Dependents are entitled to special enrollment rights, as required by HIPAA under Code Section 9801(f), then a Participant may revoke a prior election concerning the Medical and/or Dental Plan premiums under the Premium Payment Plan and make a new election, provided that the election change corresponds with the HIPAA special enrollment event. This rule does not apply to the Health Flexible Spending Account Plan or the Dependent Care Flexible Spending Account Plan.

(c) **Judgments, Decrees and Orders**

This provision applies only to the Premium Payment Plan and to the Health Flexible Spending Account Plan.

If a court judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for a Participant's Dependent Child, a Participant may:

(1) change the Participant's election to provide health coverage for the Dependent Child, provided that the Order requires the Participant to provide health coverage; or

(2) change the Participant's election to revoke health coverage for the Dependent Child if the Order requires that another individual provide coverage under that individual's plan.

(d) **Medicare and Medicaid**

This provision applies only to the Premium Payment Plan and to the Health Flexible Spending Account Plan, as limited below.

A Participant or the Participant's Dependent Spouse or Dependent Child who receives Medical Plan coverage and who becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines) may prospectively reduce or cancel the Medical Plan coverage of the individual becoming entitled to Medicare or Medicaid.

Alternatively, if a Participant or the Dependent's Dependent Spouse or Dependent Child who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase Medical Plan coverage for such individual.

(e) **Change in Cost**

This provision applies only to Premium Payment and Dependent Care Flexible Spending Account Plans.

(1) Automatic Cost Changes

If the Premiums of a Component Plan increase or decrease insignificantly during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Participant's elective contributions. The Employer, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all of the surrounding facts and circumstances, including but not limited to, the dollar amount or percentage of the cost change.

(2) Significant Cost Increases

If the Employer determines that the cost of the Premiums for any Component Plan significantly increases during a Plan Year, the Participant may:

(i) make a corresponding increase in the Participant's elective contributions (by increasing reductions in Compensation);

(ii) revoke the Participant's election for that coverage, and in lieu thereof, receive on a prospective basis, coverage under another Component Plan offered by the Employer that provides similar coverage; or

(iii) drop coverage prospectively if there is no other Component Plan available that provides similar coverage.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a cost increase is significant in accordance with applicable law.

(3) Significant Cost Decreases

If the Plan Administrator determines that the Premiums of any Component Plan significantly decrease during a Plan Year, the Participant may change the Participant's election on a prospective basis to elect the Component Plan that has decreased in cost.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a cost decrease is significant in accordance with applicable law.

(4) Limitation on Change in Cost Provisions for Dependent Care Flexible Spending Account Plan

The above change in cost provisions apply to the Dependent Care Flexible Spending Account Plan only if the cost change is imposed by a dependent care provider who is not a "relative" of the Participant. For this purpose, a "relative" is an individual who is related as described in Code Sections 152(d)(2)(A) through (G), incorporating the rules of Code Sections 152(f)(1) through (4).

(f) **Change in Coverage**

This provision applies only to the Premium Payment Plan and the Dependent Care Flexible Spending Account Plan.

(1) Significant Curtailment

If coverage is significantly curtailed, a Participant may change elections to another plan option that provides similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a Loss of Coverage, a Participant may drop coverage if no similar coverage is offered by the Employer.

(i) If the Plan Administrator determines that a Participant's coverage under a Component Plan (or the Participant's Dependent's coverage under the Dependent's employer's plan) is significantly curtailed without a Loss of Coverage during a Plan Year, the Participant may revoke the Participant's election for the affected coverage, and in lieu thereof, prospectively elect coverage under another plan option that provides similar coverage.

(ii) If the Plan Administrator determines that a Participant's benefit (such as the Participant's Dependent coverage under the Dependent's employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Plan Year, the Participant may revoke the Participant's election for the affected coverage, and may either prospectively elect coverage under another plan option that provides similar coverage, or drop coverage if no Component Plan providing similar coverage is offered by the Employer.

(2) Addition or Significant Improvement of a Component Plan

If during a Plan Year the Plan adds a new Component Plan or significantly improves an existing Component Plan, the Plan Administrator may permit a Participant who is enrolled in a Component Plan other than the newly-added or significantly improved Component Plan, to change the Participant's election on a prospective basis to elect the newly-added or significantly improved Component Plan.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been the addition of, or a significant improvement in, a Component Plan in accordance with applicable law.

(3) Loss of Coverage Under Other Group Health Coverage

A Participant may prospectively change the Participant's election to add Medical Plan Coverage for the Participant or the Participant's Dependents if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Component Plan.

(4) Change in Coverage Under Another Employer Plan

A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Dependent's employer), as long as:

(i) the other employer plan permits its participants to make an election change that would be permitted under applicable law; or

(ii) the Plan permits Participants to make an election for a Plan Year that is different from the Plan Year under the other employer plan.

The Plan Administrator in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(5) Dependent Care Flexible Spending Account Plan Changes

A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider.

(g) **Enrollment in Marketplace Coverage**

A Participant may revoke coverage under the Medical Plan in order to enroll in a qualified health plan at a health insurance marketplace during the marketplace's special enrollment periods or open enrollment period. Enrollment in such qualified health plan must be effective as of the date immediately following the effective date of the revocation of the coverage under this Plan.

(h) **Other Changes**

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, may allow other changes in elections if the Plan Administrator determines that the change is authorized by the Code and corresponding regulations.

5.5 TERMINATION OF PARTICIPATION IN COMPONENT PLANS

A Participant's termination of participation in the Plan is governed by Article II. However Participant's termination of participation in the Medical, Dental and/or Life Insurance Plan or a Component Plan, however, is governed by the specific provisions governing termination under such plans. Termination of participation will automatically revoke the Participant's elections under this Plan.

5.6 PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT

Notwithstanding anything in this Plan to the contrary, if a Participant loses eligibility for the Plan due to termination of employment and is then rehired or becomes eligible for the Plan within 30 days of the termination of employment, the elections made by the former Participant prior to the termination of employment or loss of eligibility will be reinstated. If the former Participant is rehired more than 30 days following a termination of employment, the newly-Eligible Employee may make new elections as described in Section 5.1

5.7 LEAVES OF ABSENCE

(a) Paid Leave

In the event a Participant takes a paid leave of absence, including paid leave pursuant to the FMLA or state law granting similar rights, but does not terminate employment, then participation in the Plan and the Component Plans shall continue during such leave of absence, unless the Participant elects to terminate participation in one or more Component Plans during a paid FMLA leave, in which case the Participant may change the Participant's election under the Plan to conform to the termination of participation and may reinstate the Participant's elections upon return to work after the paid FMLA leave.

(b) Unpaid Leave

(1) FMLA Leave – Medical and Dental Plan Coverage

Notwithstanding any provisions to the contrary in the Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Plan Medical and Dental Plan Coverage elected under the Plan on the same terms and conditions as if the Participant was not on FMLA leave.

If the Participant elects to continue coverage while on unpaid FMLA leave, then the Participant may elect to pay the Participant's share of the cost of coverage of the Medical and/or Dental Plans and the Health Flexible Spending Account Plan in one of the following ways:

(i) with after-tax dollars, by sending monthly payments within 30 days of the date the payment is due;

(ii) to the extent allowed by applicable law, on a pre-tax basis out of pre-FMLA Compensation by pre-paying all or a portion of the Participant's cost of coverage for the expected duration of the leave. To pre-pay the Participant's cost of coverage, the Participant must make a special election to that effect prior to the date such Compensation would normally be made available; or

(iii) under another arrangement agreed upon by the Participant and the Employer, such as an agreement whereby the Employer funds coverage during the leave and then withholds catch-up amounts from the Participant's Compensation upon the Participant's return on a pre-tax or after-tax basis.

If a Participant's coverage under the Medical and/or Dental Plans funded through the Premium Payment Plan or coverage under the Health Flexible Spending Account Plan ceased while the Participant was on an unpaid FMLA leave, the Participant is entitled to re-enter the Medical and/or Dental Plans previously elected under the Premium Payment Plan and the amount

elected under the Health Flexible Spending Account Plan on the same basis as elected prior to the FMLA leave, or as required by the FMLA.

Notwithstanding the preceding paragraph, with respect to the Health Flexible Spending Account Plan, a Participant whose coverage ceased will be entitled to elect whether to be reinstated at the same coverage level as in effect before the unpaid FMLA leave, increase contributions for the remaining Plan Year (plus applicable Grace Period), or at a coverage level that is reduced pro-rata for the period of the unpaid FMLA leave during which the Participant did not make required contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of unpaid FMLA leave, the amount will be withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for the reinstated benefits under the Health Flexible Spending Account Plan.

(2) FMLA Leave – Coverage for Other Benefits

If a Participant goes on a qualifying leave under the FMLA, entitlement to coverage other than the Medical and/or Dental Plan and HFSA Plan will be determined by the Employer's policy for providing such benefits while the Participant is on a non-FMLA leave, as described in (3) below. If such a policy allows a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave be required to repay such contributions not paid by the Participant during the leave.

(3) Non-FMLA Leave of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility for one or more of the Component Plans, then the Participant will continue to participate and the contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Employer. If a Participant goes on an unpaid leave that affects eligibility for one or more of the Component Plans, the Change Event rules of Article V will apply. If a Participant is allowed to discontinue contributions while on leave, the Participant will, upon returning from leave be required to repay such contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Employer and the Participant or as the Employer deems otherwise appropriate.

**ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT PLAN**

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this HFSA Plan may submit claims for the reimbursement of Qualifying Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly. Participants enrolled in the High Deductible Health Plan are not eligible to participate in the Health Flexible Spending Account Plan.

6.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefit Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for each Participant who makes an election to participate in the HFSA Plan. The Plan, however, will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a recordkeeping account with the purpose of keeping track of contributions, reimbursements paid, and determining forfeitures under Section 6.5 below.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers; or

(2) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Qualifying Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise reimbursed or paid to the Participant by the Medical Plan or any other group health plan, insurance, or otherwise. "Qualifying Medical Expenses" can be incurred by the Participant and the Participant's Dependents.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or the Participant's Dependents.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

A Participant may not be reimbursed for over-the-counter drugs or medications unless they are prescribed, with the exception of insulin.

(d) **Other Definitions.** The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account Plan.

6.3 BENEFITS UNDER THE HEALTH FSA PLAN

If a Participant elects to participate in the HFSA Plan, the Participant will receive benefits in the form of reimbursement for Qualifying Medical Expenses. Benefits will be funded by Participant contributions through reductions in Compensation, as provided in Section 3.1, or as otherwise provided by the Plan, and will be equal to the annual reduction in Compensation amount elected on the election form for the HFSA Plan. Unless an exception under Section 5.4 applies, such election is irrevocable for the duration of the Plan Year and applicable Grace Period to which it relates.

The maximum amount of benefits elected by the Participant shall be available to a Participant at all times during the Plan Year and Grace Period (reduced by prior reimbursements during the Plan Year and Grace Period), regardless of the actual amount in the Participant's HFSA Account, pursuant to Section 6.4. Notwithstanding the foregoing, no benefits will be available under the HFSA Plan for Qualifying Medical Care Expenses incurred after coverage under the HFSA Plan has terminated, unless a Participant has elected COBRA Continuation Coverage as described in Section 6.10. Payment shall be made to the Participant in cash as reimbursement for Qualifying Medical Care Expenses incurred during the Plan Year and Grace Period for which a Participant's election is effective, provided the other requirements of this HFSA Plan are satisfied.

6.4 CREDITING AND DEBITING OF HFSA PLAN ACCOUNT

As described in this Article, a Participant's HFSA Plan Account shall be credited periodically during the Plan Year with Compensation Reduction Amounts elected pursuant to a Participant's election form. A Participant's HFSA Plan Account shall have a zero balance at the beginning the Plan Year and the balance shall increase each pay period in which Compensation is reduced under Section 3.1 (or with each after-tax payment made during an approved leave of absence or during COBRA participation) and the balance shall decrease by the amount of any reimbursements made to the Participant under Section 6.3. The maximum amount of benefits elected by the Participant shall be available at all times during the Plan Year and Grace Period (reduced by prior reimbursements during the Plan Year and Grace Period), regardless of the actual amount in the Participant's HFSA Plan Account.

6.5 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year and Grace Period (and after the processing of all claims for such Plan Year and Grace Period) shall be forfeited and (1) returned to the Employer or (2) used to reduce the cost, as determined by the Employer, of administering the HFSA Plan during the Plan Year or any subsequent Plan Year, or as otherwise permitted by applicable law. In addition, any benefits that have been paid and are unclaimed by the close of the Plan Year following the Plan Year in which the Qualifying Medical Care Expense was incurred shall be forfeited and applied as described in the previous sentence. In such event, the Participant shall have no further claim to such amount for any reason.

6.6 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, no more than \$2,700 (or such higher amount as allowed by the Code based on index calculations for inflation for taxable years beginning after December 31, 2013) may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year.

6.7 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this HFSA Plan, it may, but shall not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the benefits designated for the Health Flexible Spending Account Plan by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account Plan for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and used as set forth in Section 6.5.

6.8 COORDINATION WITH FLEXIBLE BENEFIT PLAN

Only Participants in the Plan are eligible to receive benefits under this Health Flexible Spending Account Plan. Matters concerning contributions, elections and the like shall be governed by the general provisions of the Plan.

6.9 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year and Grace Period.** All Qualifying Medical Expenses incurred by a Participant and the Participant's Dependents shall be reimbursed if a timely claim is made, even if the submission of such a claim occurs after participation hereunder ceases; but provided that the Qualifying Medical Expenses were incurred during the applicable Plan Year and Grace Period and while the Participant was a Participant in the Plan. Qualifying Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year and Grace Period.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Qualifying Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Qualifying Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Qualifying Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if

reimbursed from the Health Flexible Spending Account Plan, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Qualifying Medical Expenses incurred in any Plan Year and Grace Period shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 120 days after the end of the Plan Year, those Qualifying Medical Expense claims shall not be considered for reimbursement by the Administrator. All claims must be submitted in accordance with the directions of the Plan Administrator, and must be substantiated in a manner that complies with the applicable Code rules and federal regulations and guidance.

(e) **Ordering Rule.** If a request for reimbursement of a Qualifying Medical Expenses is submitted during the Grace Period and the Participant has a balance in the Participant's Health Flexible Spending Account from the immediately previous Plan Year, the benefits for such expenses shall be paid from the Health Flexible Spending Account for the previous Plan Year until such Account reaches a zero balance before any benefits will be paid from the Health Flexible Spending Account for the current Plan Year.

6.10 COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage shall be offered to Participants who are the Health Flexible Spending Account Plan and their qualifying family members in accordance with COBRA and the terms of this Section 6.10.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. The terms used in this Section 6.10, not otherwise defined in the Plan, shall have the meaning given them by COBRA.

A Participant has a qualifying event under COBRA if eligibility for the Health Flexible Spending Account Plan is lost due to termination of employment or reduction of hours of employment. Dependents may qualify for COBRA continuation coverage under these and other qualifying events as provided by COBRA. A Participant is only considered a qualified beneficiary with COBRA rights and benefits if the Participant was enrolled in the HFSA Plan on the day before the qualifying event which triggered the right to elect COBRA, and if the benefits the Participant could receive from the HFSA Plan during the remaining portion of the Plan Year and applicable Grace Period exceed the total of the contributions which the Participant will be required to pay for the remainder of the Plan Year in accordance with the Participant's enrollment election form. This occurs where a Participant has paid more in contributions to the HFSA Plan during the Plan Year up to the date of the qualifying event than the amount of benefits the Participant has received from the HFSA.

In order to receive COBRA Continuation Coverage, Participants are required to give the Employer notice of following qualifying events: divorce of the Participant and Spouse or a Dependent child's losing eligibility as a dependent child. The Participant must notify the Employer within 60 days after the qualifying event occurs. This notice must be in writing to Employer in accordance with the Notice Procedures in the next paragraph. If a Participant does not give written notice of these events to the Employer, the Participant and the Participant's Dependents lose their rights to COBRA coverage.

Any notice that a Participant is required to provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The Participant must mail, fax or hand-deliver notice to the person, department or firm listed below, at the following address:

Alaska Railroad Corporation

Human Resources
P.O. Box 107500
Anchorage, AK 99510-7500

Any notice the Participant must provide must state: (1) the name of the HFSA Plan; (2) the name and address of the Participant covered under the HFSA Plan; (3) the name(s) and address(es) of the qualified beneficiary(ies); and (4) the qualifying event and the date it happened. If the qualifying event is a divorce or legal separation, the notice must include a copy of the divorce decree or the legal separation agreement.

For an individual electing COBRA coverage, COBRA coverage will automatically terminate before the end of the Plan Year and applicable Grace Period if one of the following occurs: (1) the Employer terminates the HFSA Plan; (2) a COBRA premium, other than the first premium, is not paid within 30 days of its due date; (3) the individual first becomes covered after the date the individual elects COBRA continuation coverage under another medical reimbursement plan and/or other group health plan which does limit or exclude any of the individual's pre-existing conditions; or (4) the individual first becomes entitled to Medicare benefits after the date the individual elects COBRA coverage.

If a Participant or family member qualifies for COBRA continuation coverage under the HFSA Plan, the COBRA continuation coverage will last only until the end of Grace Period for the Plan Year.

The HFSA Plan charges a premium for COBRA Continuation Coverage, not to exceed 102% of the cost of providing the coverage for the period to similarly situated employees or dependents. Participants who qualify for and elect COBRA coverage before the receipt of their final paycheck may, but are not required to, pay their COBRA premiums for the HFSA Plan for all or part of the remainder of the Plan Year from their final paycheck on a pre-tax basis under the Flexible Benefit Plan. The COBRA premiums must be paid by the following due dates: (1) the first payment is due within 45 days of the date COBRA is elected; (2) the due date for the other premiums is the 1st of the month. COBRA continuation coverage will be terminated if the first payment is not made within 45 days of the date COBRA is elected or if the subsequent payments are not made within 30 days of the due dates. There are no COBRA premiums due for the Grace Period.

6.11 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Plan Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("Cards") provided by the HFSA Plan for payment of certain Qualifying Medical Expenses, subject to the following terms:

(a) **Card Only for Qualifying Medical Expenses.** Each Participant issued a Card shall certify that such Card shall only be used for Qualifying Medical Expenses. The Participant shall also certify that any Qualifying Medical Expense paid with the Card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits. In addition, until such time as allowed by applicable regulation or guidance of the Treasury Department or the Internal Revenue Service, the Card may not be used to purchase prescribed over-the-counter drugs or medications.

(b) **Card Issuance.** Such Card shall be issued upon the Participant's initial enrollment, and reissued periodically as determined by the Plan Administrator while the

Participant remains a Participant in the HFSA Plan. Such Card shall be automatically cancelled at the end of the month (1) in which the Participant's death or termination of employment occurs, or (2) in which the Participant has a change in status that results in the Participant's withdrawal from the HFSA Plan.

(c) **Maximum Dollar Amount Available.** The dollar amount of coverage available on the Card shall be the amount elected by the Participant under the HFSA Plan for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.6. The Card is only available for use with certain service providers. The Cards shall only be accepted by such merchants and service providers as have been approved by the Plan Administrator.

(d) **Card Use.** The Cards shall only be used for Qualifying Medical Expense purchases at these providers, including, but not limited to, the following:

- (1) Co-payments for doctor and other medical care;
- (2) Purchase of prescription drugs;
- (3) Purchase of medical items such as eyeglasses, syringes, or crutches.

The HFSA Plan may charge a Participant's Health Flexible Spending Account a reasonable fee if the Participant requests a replacement Card from the HFSA Plan.

(e) **Substantiation.** Such purchases by the Cards shall be subject to substantiation by the Plan Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Plan Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43, Notice 2006-69, and any other applicable guidance by the Treasury Department or the Internal Revenue Service. All charges shall be conditional pending confirmation and substantiation.

(f) **Correction Methods.** If a Card purchase is later determined by the Plan Administrator to not qualify as a Qualifying Medical Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the HFSA Plan whole. Until the amount is repaid, the Plan Administrator shall take further action to ensure that further violations of the terms of the Card do not occur, up to and including denial of access to the Card.

- (1) Repayment of the improper amount by the Participant;
- (2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
- (3) Claims substitution or offset of future claims until the amount is repaid; and
- (4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

**ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN**

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account Plan is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this plan may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Flexible Benefit Plan the terms below shall have the following meaning:

(a) **“Dependent Care Flexible Spending Account”** means the account established for each Participant who makes an election to participate in the DCFSA Plan. The Plan, however, will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a recordkeeping account with the purpose of keeping track of contributions, reimbursements paid, and determining forfeitures under Section 7.8 below. Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants from the Participant's DCFSA Account.

(b) **“Earned Income”** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **“Employment-Related Dependent Care Expenses”** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any periods for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **“Qualifying Dependent”** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Participant's Dependent Spouse or other Dependent of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) **Other Definitions.** The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account Plan.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to contribute to the Dependent Care Flexible Spending Account Plan.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Compensation Reduction Amount that the Participant has elected to apply toward the Participant's Dependent Care Flexible Spending Account for such pay period pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid to the Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Plan, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses incurred during the Plan Year and Grace Period or portion thereof during which the person is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the

prior calendar year. This requirement may be satisfied by providing the required information on benefits in Box 10 of the Employee's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year and Grace Period (and after the processing of all claims for such Plan Year and Grace Period pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)). In addition, the minimum amount that can be contributed by a Participant in Plan Year to the Participant's Dependent Care Flexible Spending Account is \$100.

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH FLEXIBLE BENEFIT PLAN

All Participants under the Flexible Benefit Plan who have submitted timely election forms are eligible to receive benefits under this Dependent Care Flexible Spending Account Plan. The termination of participation under the Flexible Benefit Plan shall constitute termination of participation under this Dependent Care Flexible Spending Account Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Flexible Benefit Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Employment-Related Dependent Care Expense claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and Grace Period and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Plan for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- (a) The Dependent or Dependents for whom the services were performed;
- (b) The nature of the services performed for the Participant, the cost of which the Participant wishes reimbursement;
- (c) The relationship, if any, of the person performing the services to the Participant;
- (d) If the services are being performed by a child of the Participant, the age of the child;
- (e) A statement as to where the services were performed;
- (f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- (g) If the services were being performed in a day care center, a statement:
 - (1) that the day care center complies with all applicable laws and regulations of the state of residence,
 - (2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
 - (3) of the amount of fee paid to the provider.
- (h) If the Participant is married, a statement containing the following:
 - (1) the Spouse's salary or wages if the Spouse is employed, or
 - (2) if the Participant's Spouse is not employed, that
 - (i) the Spouse is incapacitated, or
 - (ii) the Spouse is a full-time student attending an educational institution and the months during the year which the Spouse attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 120 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

7.13 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Employment-Related Dependent Care Expenses, subject to the following terms:

(a) **Card only for dependent care expenses.** Each Participant issued a card shall certify that such card shall only be used for Employment-Related Dependent Care Expenses. The Participant shall also certify that any Employment-Related Dependent Care Expense paid with the card has not already been reimbursed by any other plan covering dependent care benefits and that the Participant will not seek reimbursement from any other plan covering dependent care benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Dependent Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Dependent Care Flexible Spending Account.

(c) **Only available for use with certain service providers.** The cards shall only be accepted by such service providers as have been approved by the Administrator. The cards shall only be used for Employment-Related Dependent Care Expenses from these providers.

(d) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(e) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as an Employment-Related Dependent Care Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

**ARTICLE VIII
PREMIUM PAYMENT PLAN**

8.1 PREMIUM PAYMENT PLAN

All Participants of the Plan are eligible to participate in the Premium Payment Plan. If a Participant elects to enroll in the Medical and/or Dental Plan, the Participant is electing to pay the Participant's contributions or premiums for the Medical and/or Dental Plan through reductions in Compensation. If the Participant is enrolled in the Life Insurance Plan, the Participant is electing to pay for the \$50,000 of life insurance coverage on a pre-tax basis. The Premium Payment Plan only provides for payment of the premiums for the Medical, Dental, and /or Life Insurance Plans. Reimbursement of claims under the Medical, Dental and/or Life Insurance Plans is not provided by the Premium Payment Plan.

8.2 TERMINATION OF PARTICIPATION

A Participant will cease to be a Participant in the Premium Payment Plan upon the earlier of:

- (a) termination of the Premium Payment Plan;
- (b) the end of the payroll period in which the Participant ceases to be an Eligible Employee;
- (c) the end of the payroll period in which the Participant ceases to participate in the Medical, Dental and/or Life Insurance Plans; or
- (d) the end of the payroll period in which the Participant's coverage under the Premium Payment Plan is terminated for Cause.

**ARTICLE IX
CLAIMS REVIEW PROCEDURES**

9.1 CLAIM FOR BENEFITS

(a) Any claim for Benefits under this Plan shall be made to the Administrator or its representative. If the Administrator denies a claim, the Administrator shall provide notice to the claimant, in writing, within 30 days after the claim is filed unless special circumstances require an extension of time up to an additional 15 days for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (i) specific reason or reasons for the denial;
- (ii) specific references to the pertinent Plan provisions on which the denial is based;
- (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary; and
- (iv) an explanation of the Plan's claim procedure.

(b) Within 180 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or the claimant's duly authorized representative may:

- (i) request a review upon written notice to the Administrator;
- (ii) review pertinent documents; and
- (iii) submit issues and comments in writing.

(c) A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based, any internal rules relied upon in making the decision, and a statement of the Participant's right to review relevant documents.

9.2 FORFEITURES AND APPLICATION OF BENEFIT PLAN SURPLUS

Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in the Participant's account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year and applicable Grace

Period (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year (other than during the Grace Period) for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations.

9.3 HSA TRUSTEE AND NO FIDUCIARY RESPONSIBILITIES FOR HSA INVESTMENTS

All HSA Benefits provided under this Plan will be deposited in an HSA established by the Participant with an HSA trustee or custodian selected by the Employer. The Participant participating in HSA Benefits is responsible for establishing and maintaining a Health Savings Account with such HSA trustee or custodian in a timely fashion as directed by the Employer. After funds have been deposited into the Participant's HSA with such HSA trustee or custodian, the Participant may transfer any amounts so deposited to another HSA trustee or custodian of the Participant's choice ("Alternative Trustee"). However, the Participant is responsible for any and all fees or charges imposed by an Alternative Trustee. Any HSA trustee or custodian, including one selected by the Employer may offer investment options for HSAs. Notwithstanding any other provision of this Plan, neither the Employer, the Plan Administrator, nor any other official or employee of them (1) has reviewed any investment options offered by an HSA trustee or custodian; (2) endorses or recommends any HSA trustee or custodian or any investment options offered by such HSA trustee or custodian; (3) is a Plan fiduciary with respect to the investment designation or direction of a Participant regarding an HSA. Participants are solely responsible for their actions concerning the establishment and maintenance of their Health Savings Account or Accounts and HSA investment decisions and should consult a tax advisor or financial consultant to determine what, if any, investments are appropriate for them.

9.4 NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE X ADMINISTRATION

10.1 PLAN ADMINISTRATION

The operation of the Plan (including all Component Plans) shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan and Component Plans are carried out in accordance with Plan terms and with applicable law. The Administrator shall have full power to administer the Plan and Component Plans in all details, subject, however, to the pertinent provisions of the Code. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. All of the Administrator's decisions relating to the Plan are final and binding on all persons except to the extent found to be arbitrary and capricious. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan and the Component Plans:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan and Component Plans, including procedures to be followed by Participants in obtaining benefits;

(b) To interpret the Plan and Component Plans, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming Plan benefits;

(c) To make factual determinations upon which decisions as to benefits are based, to decide all questions concerning the Plan and the Component Plans and the eligibility of any person to participate in the Plan and Component Plans and to receive benefits provided by operation of the Plan and Component Plans;

(d) To reject elections or to limit contributions or benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan or Component Plans in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their Plan benefits and to assist Participants regarding their rights, benefits or elections under the Plan;

(f) To review and settle all claims against the Plan, and to approve reimbursement requests and to authorize the payment of benefits; and

(g) To appoint such agents, counsel, accountants, consultants, actuaries and other persons or entities as may be required to assist in administering the Plan and the Component Plans.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

10.2 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an insurance Contract of an independent third party insurer whose product is then being used in

conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

10.3 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

10.4 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant or other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

10.5 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any trust fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

10.6 ADMINISTRATIVE ERRORS REGARDING HSA BENEFITS

If the Employer makes an administrative or other error under which the Employer contributes funds to a Participant's HSA in excess of the HSA Benefits provided under this Plan ("Excess Contribution"), and the Employer is unable to obtain a refund of the Excess Contribution from the HSA custodian or trustee, the Participant is required to repay the Employer the Excess Contribution. As a condition of participating in this Plan, Participants receiving such excess HSA Benefits agree to repay the Employer any such Excess Contributions. The Employer may require the Participant to repay the Excess Contribution via payroll deduction or may allow the Participant to repay the Excess Contribution in another manner agreed to by the Employer and the Participant. If a Participant's employment is terminated before the Participant has repaid the Excess Contribution, the Employer may deduct the remaining repayment amount of the Excess Contribution from the Participant's last payroll check from the Employer.

**ARTICLE XI
AMENDMENT OR TERMINATION OF PLAN**

11.1 AMENDMENT

The Plan may at any time and from time to time be amended or modified, by written instrument executed by the Chief Executive Officer of the Employer or any individual(s) acting pursuant to written authorization of the Chief Executive Officer to amend or modify the Plan. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

11.2 TERMINATION

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time, by resolution of the Board of Directors or by written action of an Employee of the Employer to whom the Board of Directors has delegated the right to terminate the Plan.

ARTICLE XII MISCELLANEOUS

12.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 12.10.

12.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in any gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

12.3 WRITTEN DOCUMENT

This Plan is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

12.4 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

12.5 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

12.6 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

12.7 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted benefit, 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 (plus any

penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the 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.

12.8 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

12.9 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Alaska.

12.10 SEVERABILITY

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

12.11 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

12.12 REFUNDS

If it is determined that the Plan has made a payment or overpayment of benefits to which a Participant is not entitled, the Administrator may deduct the amount of such payment or overpayment from future payments of claims otherwise payable under the Plan to the Participant. If the Plan for any reason is not able to make such a deduction, Participants must repay such payment or overpayment to the Plan. Participants not complying with this Section may, in the discretion of the Employer, lose eligibility to participate in the Plan.

12.13 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, the HFSA Plan shall be operated in accordance with HIPAA and regulations thereunder.

12.14 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, the Plan shall comply with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder, to the extent applicable.

12.15 COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS FOR HFSA PLAN

(a) **Application.** This Section 12.15 applies only to the HFSA Plan. To the extent any term used in this Section is not defined in the Plan, the term shall have the meaning as defined under HIPAA.

(b) **Disclosure of PHI.** The HFSA Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met.

(c) **Summary Health Information.** The HFSA Plan may disclose summary health information to the Employer if the Employer requests the summary information for the purpose of (1) obtaining premium bids for providing insurance coverage; or (2) modifying, amending, or terminating the HFSA Plan. The Employer may use summary information so received from the HFSA Plan only for these two listed purposes.

(d) **Enrollment Information.** The HFSA Plan may disclose to the Employer, and the Employer may use, information on whether an individual is participating in the HFSA Plan or is enrolling or disenrolling in the HFSA Plan.

(e) **Authorization.** The HFSA Plan may disclose PHI to the Employer and the Employer may use such PHI if the Participant or Dependent has specifically authorized in writing such disclosure and/or use.

(f) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of HFSA Plan administrative functions. The HFSA Plan's administrative functions shall include all HFSA Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill HFSA Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. PHI that is genetic information will not be used or disclosed for underwriting purposes.

(g) **PHI disclosed to certain workforce members.** The HFSA Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform the person's duties with respect to the HFSA Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform the member's duties with respect to the HFSA Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the HFSA Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(h) **Certification.** By adopting the HFSA Plan, the Employer hereby certifies to the HFSA Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the HFSA Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the HFSA Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information. Any agents or subcontractors of the Employer to whom the Employer provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the HFSA Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law. The Employer will report to the HFSA Plan any security incident of which the Employer becomes aware.

(5) Make available Protected Health Information to individual HFSA Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual HFSA Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual HFSA Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the HFSA Plan available to the Department of Health and Human Services for purposes of determining compliance by the HFSA Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the HFSA Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(10) Ensure the adequate separation between the HFSA Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above; and

(11) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the HFSA Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

IN WITNESS WHEREOF, the Railroad has caused the Restatement of the Alaska Railroad Corporation Flexible Benefit Plan, as adopted herein, to be duly executed this _____ day of, _____ 2020.

ALASKA RAILROAD CORPORATION

By: _____

Its: _____
Title

Witness

APPENDIX A

PLAN PROVISIONS APPLICABLE TO EMPLOYEES COVERED UNDER A COLLECTIVE BARGAINING AGREEMENT

1. ALASKA RAILROAD WORKERS/AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES/UNITED TRANSPORTATION UNION EMPLOYEES

Required service period: 90 cumulative calendar days

Health FSA Limitations: Be employed in a year-round job. Have had 12 months of continuous employment prior to January 1 of the Plan Year, with no unpaid leaves or layoffs during those 12 months. Anticipate continuous employment for the next 12 months. If a non-paid leave or a layoff is expected in the upcoming year, the employee may not participate in the Plan.

2. INTERNATIONAL BROTHERHOOD OF TEAMSTERS

Required service period: 90 cumulative calendar days

Health FSA Limitations: Same as other Plan Participants.

3. AMERICAN TRAIN DISPATCHERS ASSOCIATION

Required service period: 90 cumulative calendar days

Health FSA Limitations: Same as other Plan Participants

4. TRANSPORTATION COMMUNICATION INTERNATIONAL UNION

Required service period: 90 cumulative calendar days

Health FSA Limitations: Same as other Plan Participants