Summary Plan Description (2025)

For Lilly Enterprises Inc

Section 125 Premium Only Plan

Plan Year Ending December 31, 2025

We are pleased to announce that we have updated the Premium Only Plan for you and other eligible employees. Under this program, you will be able to pay for employer-sponsored benefits (health plans, group-term life insurance for yourself, Health Savings Accounts, etc., as applicable based on the insurance coverages or other allowable benefits your Employer offers under the Plan) with a portion of your pay before federal income or Social Security taxes, if applicable are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description (SPD) carefully so that you understand the provisions of our Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information about the Plan."

Overview:

This section contains general information, which you may need to know about the Lilly Enterprises Inc Premium Only Plan.

General Information:

1. Lilly Enterprises Inc Premium Only Plan is the name of the Plan.
2. The provisions of your Amended Plan became effective on January 1, 2025. Your Plan was originally effective on January 1, 2020 which is called the Effective Date of the Plan.
3. Your Plan’s records are maintained over a twelve-month period. This is known as the Plan Year. The amended plan year begins on January 1, 2025 and ends on December 31, 2025. Future plan years will be based on the same twelve-month period beginning each **January 1** and ending each **December 31**.
4. Your Employer has assigned Plan Number 520 to your Plan.
5. This Plan is unfunded, meaning it is not otherwise provided under a separate trust arrangement or fully-insured insurance arrangement.

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Employer Information:

Your Employer's name, address, business telephone number, and tax identification number are:

Lilly Enterprises Inc
PO Box 2920
Athens, TX 75751
Telephone: (903) 677-4806
Federal Employer I.D. Number: 75-2700345

Plan Administrator Information:

The name, address, business telephone number, and tax identification number of your Plan's Administrator are:

Lilly Enterprises Inc
PO Box 2920
Athens, TX 75751
Telephone: (903) 677-4806
Federal Employer I.D. Number: 75-2700345

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Lilly Enterprises Inc
PO Box 2920
Athens, TX 75751
Telephone: (903) 677-4806
Federal Employer I.D. Number: 75-2700345

Type of Administration

The type of administration is Insurer Administration.

Unless the Plan provides otherwise, the Administrator keeps the records for the Plan and is responsible for the administration and interpretation of the Plan. The Administrator will also answer any questions you may have about the Plan.

1. How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your future salary or other compensation amount contributed to the Plan in lieu of receiving those amounts in cash (i.e., your future salary or other compensation will be automatically reduced by the amount elected as a contribution to the Plan). The money contributed will be used to pay for benefits you have elected based on the options sponsored by your Employer (and as identified on your "Election to Participate" form). The portion of your pay that is contributed to pay for the benefits provided for under the Plan is not subject to Federal income or Social Security taxes. In other words, the Plan allows you to use tax-free dollars to pay for insurance coverage, premium amounts, or other allowable plan contributions or expenses which you normally pay for with out-of-pocket, taxable dollars.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the benefits or programs you desire to pay for through the Plan with your own pre-tax contributions. Then, during each pay period during that next Plan Year, the contributions deducted from your paycheck will be used to pay your portion of your employer-sponsored benefit coverage (health plan, life insurance, Health Savings Account contributions, etc.). With the exception of HSA contributions that remain available for your use under terms established under your HSA arrangement, any other contribution amounts that are not used during a Plan Year to provide insurance

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benefits will be forfeited and may not be paid to you in cash or used to provide benefits specifically for you in a later Plan year.

3. When Must I Decide Whether to Participate?

You are required by Federal law to decide whether you want to pay premiums through the Plan before the Plan Year begins. This is called the "election period." If for some reason you do not complete an election to participate in the Plan during that Plan Year, you will be considered to have elected not to participate in the Plan for that Plan Year, and, therefore, you will receive the full amount of your salary or other compensation without reduction for Benefits provided hereunder, or any reduction on applicable employment tax costs.

4. When Is the "Election Period" for Our Plan?

Your election period will start on the date you first meet the "eligibility requirements" and end 30 days after your "entry date." Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period.

5. May I Change My Elections During the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance, including a change to cover adult children who have not attained age 27 as of the end of the taxable year; and
- A change in the place of residence of you, your spouse or dependent.

There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed, and such curtailment results in a loss of coverage, or ceases during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, or significantly improve an existing option, you may elect the newly added or improved option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

If you elected to salary reduce through your Employer's Premium Only Plan for accident and health plan coverage, you are allowed to prospectively revoke or change your election with respect to the accident or

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health plan to begin participation during open enrollment or a Special Enrollment Period, such as marriage or addition of dependent, of a Marketplace Qualified Health Plan (QHP). The new coverage in the QHP must be effective no later than the day immediately following the last day of the original coverage that is revoked.

If you elected to salary reduce through your Employer's Premium Only Plan for accident and health plan coverage, and you moved from full-time status (at least 30 hours of service per week), to part-time status (less than 30 hours of service per week), even if the reduction in hours does not result in you ceasing to be eligible under the group health plan, you are allowed to prospectively revoke or change your election with respect to the accident or health plan and seek coverage in another plan that provides minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

In addition, a change in compensation or a financial "hardship" is not a reason to change your election amount.

If you have declined enrollment in the Plan for you or your dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program (SCHIP), there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if you declined enrollment in the Plan for you or your dependents (including spouse), and later become eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

The Plan may permit you to make a prospective election change that is on account of and corresponds with a change made under a spouse's or dependent's employer plan if the election for a period of coverage for this Plan is different from the period of coverage (open enrollment) under the other cafeteria plan or qualified benefits plan.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

6. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the "election period" before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year. New elections must be made during the "election period" prior to the beginning of each Plan Year. However, any Eligible Employee who was a Participant in the Plan prior to the date this Plan update became effective shall continue to be eligible to participate in the Plan unless some other termination event has occurred in the interim.

7. What Insurance Coverage May I Purchase?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay premiums on a pre-tax basis for any one or more health insurance, disability insurance, or group-term life insurance policies that we decide to offer through the Plan. However, you should note that if disability insurance is paid for on a pre-tax basis, any benefits you receive under your disability insurance policy may be taxable. You should contact your own tax advisor or accountant to determine the most appropriate election for these coverages under the Plan.

Certain limits may apply on the amount of coverage that we obtain on your behalf. The insurance contracts will normally control.

Your Employer may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment,

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are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

However, for group-term life insurance policies, employees may not pay premiums that cover spouses or dependents on a pre-tax basis, even if the amount is de minimis.

8. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced, because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

9. What if I take a Family or Medical Leave?

If you take an unpaid leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and participate in annual enrollment. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you must reinstate coverage for the remaining portion of the Plan Year upon your return.

Your employer may choose to continue coverage on your behalf during your FMLA leave. Your employer will arrange a schedule for you to "catch up" your payments when you return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage through payroll deduction prior to the start of your leave provided such payroll deduction is for benefits within the remaining portion of the plan year, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

If you take a paid leave under the Family and Medical Leave Act, you may participate in annual enrollment, and you will be required to continue coverage while on FMLA, your share of the premiums being paid by the method normally used during any paid leave.

In all instances, a paid or unpaid leave under FMLA will be treated in the same manner and consistent with a non-FMLA paid or unpaid leave.

10. Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a "highly compensated employee" or a "key employee".

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. These provisions are also applicable if your Employer makes Employer contributions through the Plan on your behalf.

Your own circumstances will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

11. What Happens If I Terminate Employment?

If you leave our employ during the Plan Year, you will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment. Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to you in cash or used to provide benefits specifically for you in a later Plan Year.

If you are enrolled in a Health Savings Account and are making contributions through the Plan, any unused amounts within your HSA will continue to be available to you for withdrawal to pay qualified expenses on a tax-free basis, or may be distributed to you, subject to applicable IRS guidelines or the terms of your HSA account. You should contact the HSA Trustee to discuss any questions regarding any rights you may have to unused amounts held in your Health Savings Account at termination.

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12. What is a Health Savings Account?

In addition to the Premium Only Plan, described above, this Plan also may provide for contributions (via payroll deduction) to be made by you on a pre-tax basis to a “Health Savings Account” (also referred to as an "HSA Program"). The HSA is a new type of account that enables those who elect to participate in this program to pay eligible HSA Medical Expenses or allow distribution of remaining balances for other qualifying purposes. The HSA Program, if applicable, is separately provided and administered through an HSA Trustee or similar custodial account. Your Employer's election to enable you to make contributions to the HSA Program merely provides the opportunity for you to contribute such amounts through this Plan on a pre-tax basis.

In general, unless otherwise excluded from participation, all Participants under the Premium Only Plan are eligible to receive benefits under this HSA Program, as long as they are otherwise eligible to participate in the Premium Only Plan. Enrollment and termination conditions in the Premium Only Plan shall generally constitute enrollment and termination of participation under this HSA Program as well. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Premium Only Plan; if your Employer elects to allow you to make contributions through this Plan to your HSA plan, you elect the amount to have withdrawn from your salary in the same manner as otherwise set forth above. Your employer may also elect to contribute employer contribution amounts to your HSA plan, on a discretionary basis, and in accordance with the Plan's general limitations on the allowability for employer contributions overall (NOTE: you should contact the HSA Trustee for any other questions you may have about eligibility to establish or participate in an HSA, what benefits may be received through participation in such program and how contributed HSA amounts are used to pay for qualifying expenses under their program).

Once eligible and elected, the Administrator will establish a Health Savings Account for each person who elects to apply contributed amounts to the HSA Program established or provided by your HSA Trustee. (NOTE: you should contact the HSA Trustee for more information about the amount you may contribute each year. Your HSA Trustee will provide more information to you regarding the requirements for participation in the HSA program and the benefits you are entitled to hereunder. To the extent of any conflict between the terms of this Plan and the HSA program to which you are participating in, to the extent of your HSA, the terms of your HSA would control.) We are not responsible for the decisions and operations of the HSA Trustee in the administration of your HSA.

13. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

14. Summary

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our premium benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

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Descripcion resumida del plan

Por Lilly Enterprises Inc

Premium Only Plan Seccion 125

Finalizacion del Ano del plan December 31, 2025

Nos complace anunciar que hemos actualizado el Premium Only Plan para usted y otros empleados elegibles. En el marco de este programa, podra pagar los beneficios patrocinados por el empleador (planes de salud, seguro de vida grupal a termino para usted, cuentas de ahorros para la salud, etc., segun corresponda, en funcion de las coberturas de seguro u otros beneficios permitidos que su empleador ofrezca en virtud del Plan) con una parte de su sueldo antes de que se retengan los impuestos federales sobre la renta o del Seguro Social, si corresponde. Esto significa que pagara menos impuestos y tendra mas dinero para gastar y ahorrar.

Lea esta Descripcion resumida del plan (SPD, por sus siglas en ingles) detenidamente para comprender las disposiciones de nuestro Plan y los beneficios que recibira. Esta SPD describe los beneficios y las obligaciones del Plan tal y como figuran enel documento legal del Plan que rige su funcionamiento. El documento del Plan esta redactado con un lenguaje mucho mas tecnico y preciso. Si el lenguaje no tecnico de esta SPD y el lenguaje tecnico y legal del documento del Plan entran en conflicto, el documento del Plan siempre prevalecera. Ademas, si existe un conflicto entre un contrato de seguro y el documento del Plan o esta Descripcion resumida del plan, prevalecera el contrato de seguro. Si desea recibir una copia del documento legal del Plan, comuniquese con el Administrador.

Esta SPD describe las disposiciones actuales del Plan que estan diseiiadas para cumplir con los requisitos legales aplicables. El Plan esta sujeto a leyes federales, como el Codigo de Impuestos lntemos y otras leyes federales y estatales que pueden afectar sus derechos. Las disposiciones del Plan estan sujetas a revision debido a un cambio en las leyes o debido a pronunciamientos del Servicio de lmpuestos lntemos (IRS por sus siglas en ingles) u otras agencias federales. Tambien podemos modificar o cancelar este Plan. Si las disposiciones del Plan que se describen en esta SPD cambian, se lo notificaremos.

Remos intentado responder la mayoria de las preguntas que pueda tener sobre sus beneficios en el Plan. Si esta SPD no responde a todas sus preguntas, comuniquese con el Administrador (u otro representante del plan). El nombre y la direccion del Administrador se pueden encontrar en el Articulo de esta SPD titulado "Informacion general sobre el Plan."

Resumen:

Esta seccion contiene informacion general, que puede necesitar saber sobre Lilly Enterprises Inc Premium Only Plan.

Informacion general:

1. Lilly Enterprises Inc Premium Only Plan es el nombre del plan.
2. Las disposiciones de su Plan modificado entraron en vigencia el January 1, 2025. Su Plan entro en vigor originalmente el January 1, 2020, que se denomina Fecha de entrada en vigencia del Plan.
3. Los registros de su plan se mantienen durante un periodo de doce meses. Esto se conoce como el Aiio del plan. El aiio del plan modificado comienza el January 1, 2025 y finaliza el December 31, 2025. Los aiios futuros del plan se basaran en el mismo periodo de doce meses que comienza cada **January 1** y finaliza cada **December 31.**
4. Su Empleador le ha asignado el Numero de plan 520 a su Plan.
5. Este Plan no esta financiado, lo que significa que nose proporciona en virtud de un acuerdo de fideicomiso separado o un acuerdo de seguro total.

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Informacion del Empleador:

El nombre, la direccion, el numero de telefono comercial y el numero de identificacion fiscal de su empleador son:

Lilly Enterprises Inc
PO Box 2920
Athens, TX 75751
Telefono: (903) 677-4806
Identificacion federal de Empleador Numero: 75-2700345

Informacion del administrador del plan:

El nombre, la direccion, el numero de telefono comercial y el numero de identificacion fiscal del Administrador de su Plan son:

Lilly Enterprises Inc
PO Box 2920
Athens, TX 75751
Telefono: (903) 677-4806
Identificacion federal de Empleador Numero: 75-2700345

El Administrador mantiene los registros del Plan y es responsable de la administracion del Plan. El Administrador tambien respondera cualquier pregunta que pueda tener sobre nuestro Plan. Puede comunicarse con el Administrador para obtener mas informacion sobre el Plan.

Notificacion de procesos judiciales

El nombre y la direccion del agente del Plan para la notificacion de procesos judiciales son:

Lilly Enterprises Inc
PO Box 2920
Athens, TX 75751
Telefono: (903) 677-4806
Identificacion federal de Empleador Numero: 75-2700345

Tipo de administracion

El tipo de administracion es Administracion Aseguradora.

A menos que el Plan disponga lo contrario, el Administrador mantiene los registros del Plan y es responsable de la administracion e interpretacion del Plan. El Administrador tambien respondera cualquier pregunta que pueda tener sobre el Plan.

1. **;,Como funciona este plan?**
Antes del comienzo de cada Ano del Plan, podra optar para que parte de su salario futuro u otra suma de su remuneracion contribuya al Plan en lugar de recibir esas cantidades en efectivo (es decir, su salario futuro u otra remuneracion se reducira automaticamente por el monto elegido como aporte al Plan). El dinero aportado se utilizara para pagar los beneficios que haya elegido en funcion de las opciones patrocinadas por su Empleador (y segun se identifique en su formulario de "Eleccion de participar"). La parte de su sueldo que se aporta para pagar los beneficios previstos en el Plan no esta sujeta a impuestos federales sobre la renta o del Seguro Social. En otras palabras, el Plan le permite usar do1ares libres de impuestos para pagar la cobertura del seguro, los montos de las primas u otras contribuciones o gastos permitidos del plan que normalmente paga con dolares de su bolsillo sujetos a impuestos.

2. **;,Que sucede con las contribuciones realizadas al plan?**
Antes de que comience cada Ano del plan, seleccionara los beneficios o programas que desea pagar a traves del Plan con sus propias contribuciones antes de impuestos. Luego, durante cada periodo de pago de ese Ano de! plan, las contribuciones deducidas de su salario se utilizaran para pagar su parte de la cobertura de beneficios patrocinada por su empleador (plan de salud, seguro de vida, contribuciones a la Cuenta de Ahorros para la Salud, etc.). Con la excepcion de las contribuciones a la HSA que permanecen disponibles para su uso seg(m los terminos establecidos en su acuerdo de HSA, cualquier otro monto de contribucion que no se utilice durante un Ano del Plan para proporcionar beneficios de seguro se perdera y nose le podra pagar en efectivo ni se utilizara. para brindarle beneficios especificamente para usted en un ano posterior de! Plan.

3. **;,Cuando debo decidir si participar?**
La ley federal le exige que decida si desea pagar las primas a traves de! Plan antes de que comience el Ano de! plan. A esto se le llama el "periodo de eleccion." Si por alguna razon no realiza la eleccion de participar o no de! Plan durante ese Ano de! Plan, se considerara que ha elegido no participar de! Plan para ese Ano de! plan y, por lo tanto, recibira el monto total de su salario o de otra remuneracion sin reduccion para los Beneficios proporcionados en virtud del mismo, o cualquier reduccion en los costos de impuestos laborales aplicables.

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4. ;,Cuando es el "periodo de eleccion" para nuestro Plan?

Su periodo de eleccion comenzara en la fecha en que cumpla por primera vez los "requisitos de elegibilidad" y finalizara 30 dias despues de su "fecha de ingreso." Luego, para cada Ano del plan siguiente, el Administrador establece el periodo de eleccion y se aplica de manera uniforme a todos los participantes. Nonnalmente sera un periodo de tiempo anterior al comienzo de cada Aiio de! plan. El Administrador le infonnara cada ano sobre el periodo de eleccion.

5. ;,Puedo cambiar mis elecciones durante el Afio del plan?

Generalmente, no puede cambiar las elecciones que ha realizado despues de! comienzo de! Ano de! plan. Sin embargo, existen ciertas situaciones puntuales en las que puede cambiar sus elecciones. Se le permite cambiar las elecciones si tiene un "cambio de estado" y realiza un cambio de eleccion coherente con el "cambio de estado." Actualmente, la ley federal considera que los siguientes acontecimientos son "cambios de estado":

Matrimonio, divorcio, fallecimiento de un conyuge, separacion legal o anulacion;

Cambio en el numero de personas a cargo, incluido el nacimiento, la adopcion, la entrega para adopcion o la muerte de una persona a cargo;

Cualquiera de los siguientes acontecimientos para usted, su conyuge o persona a cargo: terminacion o comienzo del empleo, huelga o cierre patronal, inicio o regreso de una licencia sin goce de sueldo, un cambio en el lugar de trabajo o cualquier otro cambio en el estado laboral que afecte la elegibilidad para los beneficios;

Una de sus personas a cargo cumple o deja de cumplir con los requisitos de cobertura debido a un cambio de edad, estado de estudiante o cualquier circunstancia similar, incluido un cambio para cubrir a hijos adultos que no hayan cumplido los 27 anos al final del ai'io contributivo; y

Un cambio en el lugar de residencia de usted, su conyuge o persona a cargo.

Existen reglas detalladas sobre cuando se considera que un cambio en las elecciones es coherente con un "cambio de estado." Ademas, existen !eyes que le otorgan derecho a cambiar la cobertura medica y de accidentes para usted, su conyuge o sus personas a cargo. Si cambia de cobertura debido a los derechos que le otorga la ley, puede realizar el cambio correspondiente en sus elecciones segun el Plan. Si alguna de estas condiciones se aplica a usted, debe comunicarse con el Administrador.

Si el costo de un beneficio proporcionado en virtud del Plan aumenta o disminuye durante un Ano del plan, automaticamente aumentaremos o disminuiremos, segun sea el caso, su eleccion de redireccionamiento salarial. Si el costo aumenta significativamente, se le permitira realizar los cambios correspondientes en sus pagos o revocar su eleccion y obtener cobertura bajo otra opcion de paquete de beneficios con cobertura similar, o revocar su eleccion por completo.

Si la cobertura de un beneficio se reduce significativamente, y dicha reduccion da como resultado la perdida de cobertura, o cesa durante un Ano de! plan, puede revocar sus elecciones y optar por recibir, con vistas a futuro, la cobertura de otro plan con cobertura similar. Ademas, si agregamos una nueva opcion de cobertura o eliminamos una opcion existente, o mejoramos significativamente una opcion existente, puede elegir la opcion recien agregada o mejorada (o elegir otra opcion si una opcion ha sido eliminada) y realizar los cambios de eleccion correspondientes a otras opciones que brinden una cobertura similar. Si no es un Participante, puede optar por unirse al Plan. Tambien hay ciertas situaciones en las que es posible que pueda modificar sus elecciones debido a un cambio en el plan de\ empleador de su conyuge, ex conyuge o persona a cargo.

Si eligio reducir el salario a traves del Premium OnlyPlan de su empleador para la cobertura del plan de salud y accidentes, se le permite revocar o cambiar su eleccion a futuro con respecto al plan de accidentes o de salud para comenzar a participar durante la inscripcion abierta o un Periodo de inscripcion especial, como matrimonio o adicion de una persona a cargo, de un Plan de salud calificado de! mercado (QHP por sus siglas en ingles). La nueva cobertura en el QHP debe entrar en vigor a mas tardar el dia inmediatamente posterior al ultimo dia de la cobertura original que se revoco.

Si eligio reducir el salario a traves de! Premium Only Plan de su Empleador para cobertura de accidentes y de! plan de sa\ud, y cambio de un estado de tiempo completo (al menos 30 horns de servicio por semana) a un estado de tiempo parcial (menos de 30 horns por semana), incluso si la reduccion de horns no implica que deje de ser elegible para el plan de salud grupal; y busca cobertura en otro plan que proporcione una cobertura esencial minima. La nueva cobertura debe entrar en vigor a mas tardar el primer dia del segundo mes posterior al mes que incluye la fecha en que se revoco la cobertura original.

Ademas, un cambio en la remuneracion o una "dificultad" financiera no es razon para cambiar el importe de su eleccion.

Si ha rechazado la inscripcion en el Plan para usted o sus personas a cargo (incluido un conyuge) debido a la cobertura de Medicaid o del Programa de Segura Medico para Ninos (SCRIP, por sus siglas en ingles), es posible que tenga derecho a inscribirse en este Plan si se pierde la elegibilidad. para la cobertura proporcionada por el gobiemo. Sin embargo, se debe realizar una solicitud de inscripcion dentro de \os 60 dias posteriores a la finalizacion de la cobertura proporcionada por el gobiemo.

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Ademas, si rechazo la inscripcion en el Plan para usted o sus personas a cargo (incluido su conyuge), y luego cumple los requisitos para recibir asistencia estatal a traves de un Programa de Seguro Medico para Ninos o Medicaid que brinda ayuda para pagar la cobertura del Plan, entonces puede haber derecho a inscribirse en este Plan. Sin embargo, se debe realizar una solicitud de inscripcion dentro de los 60 dias posteriores a la determinacion del derecho a la asistencia estatal.

El Plan puede permitirle realizar un cambio de eleccion prospectivo que se deba y se corresponda con un cambio realizado en el plan del empleador de un conyuge o persona a cargo si la eleccion de un periodo de cobertura para este Plan es diferente del periodo de cobertura (inscripcion abierta) en el otro plan de cafeteria o plan de beneficios calificados.

Sin embargo, con respecto a la Cuenta de ahorros para la Salud, puede modificar o revocar sus elecciones sin que se produzca un cambio de estado.

6. ;,Puedo realizar nuevas elecciones en los futuros Aiios del plan?

Si puede. Para cada nuevo Aiio del plan, puede cambiar las elecciones que hizo anteriormente. Tambien puede optar por no participar en el Plan para el siguiente Aiio del plan. Si no realiza nuevas elecciones durante el "periodo de eleccion" antes de que comience un nuevo Aiio del plan, consideraremos que eso significa que ha elegido no participar para el siguiente Aiio del plan. Se deben realizar nuevas elecciones durante el "periodo de eleccion" antes del comienzo de cada Aiio del plan. Sin embargo, cualquier Empleado elegible que sea Participante del Plan antes de la fecha de entrada en vigor de esta actualizacion del Plan seguira siendo elegible para participar en el Plan a menos que haya ocurrido algun otro acontecimiento de recisicion en el interin.

7. ;,Que cobertura de seguro puedo adquirir?

En virtud de nuestro Plan, puede optar por recibir su remuneracion completa o utilizar una parte para pagar las primas, antes de impuestos, de una o mas polizas de seguro medico, seguro de invalidez o seguro de vida colectivo a termino que decidamos ofrecer a traves del Plan. Sin embargo, debe tener en cuenta que si el seguro de invalidez se paga antes de impuestos, cualquier beneficio que reciba en virtud de su poliza de seguro de invalidez puede estar sujeto a impuestos. Debe comunicarse con su propio asesor impositivo o contable. para determinar la eleccion mas apropiada para estas coberturas del Plan.

Es posible que se apliquen ciertos limites al monto de cobertura que obtenemos a su nombre. Los contratos de seguro normalmente prevaleceran.

Su Empleador puede rescindir o modificar los beneficios del Plan en cualquier momento, sujeto a las disposiciones del contrato de seguro que brinde los beneficios descritos anteriormente. No seremos responsables ante usted si una compaiiia de seguros no le brinda alguno de los beneficios descritos anteriormente. Ademas, su seguro terminara cuando deje el empleo, deje de ser elegible segun los terminos de las po1izas de seguro o cuando termine la cobertura del seguro.

Todos los beneficios que brindara el seguro se proporcionaran solo despues de (1) que haya entregado al Administrador la inforrnacion necesaria para solicitar el seguro y (2) que el seguro este vigente para usted.

Si cubre a sus hijos hasta los 26 aiios con su seguro, puede pagar esa cobertura a traves de! Plan.

Sin embargo, para las po1izas de seguro de vida colectivo a termino, es posible que los empleados no paguen primas que cubran a sus conyuges o personas a cargo antes de impuestos, aunque el importe sea minimo.

8. ;,Se veran afectados mis beneficios de la Seguridad Social?

Es posible que sus beneficios de la Seguridad Social disminuyan levemente, porque cuando recibe beneficios libres de impuestos con nuestro Plan, baja el monto de las contribuciones que usted realiza al sistema Federal de Seguridad Social, asi como nuestra contribucion a la Seguridad Social en su nombre.

9. ;,Que pasa si tomo una Licencia familiar o medica?

Si toma una licencia sin goce de sueldo en virtud de la Ley de Licencia Medica y Familiar, puede revocar o cambiar sus elecciones actuales de seguro medico y participar en la inscripcion anual. Si su cobertura en estos beneficios finaliza, debido a la revocacion del beneficio mientras estaba de licencia o debido a la falta de pago de sus contribuciones, debe restablecer la cobertura para la parte restante de! Aiio del Plan a su regreso.

Su empleador puede optar por continuar la cobertura en su nornbre durante su licencia FMLA. Su ernpleador organizara un cronograrna para que pueda "ponerse al dia" con sus pagos cuando regrese.

Si continua su cobertura durante su licencia sin goce de sueldo, puede pagar por adelantado la cobertura rnediante una deduccion de nornina antes de] inicio de su licencia, siernpre que dicha deduccion de nornina sea para beneficios dentro de la parte restante del aiio del plan, puede pagar su cobertura despues de irnpuestos rnientras este de licencia, o usted y su empleador pueden acordar un cronograrna para que usted "se ponga al dia" con sus pagos cuando regrese.

Si toma una licencia con goce de sueldo en virtud de la Ley de Licencia Familiar y Medica (FMLA), puede participar en la inscripcion anual y se le pedira que continue con la cobertura mientras este bajo FMLA, y su parte de las prirnas se pagara rnediante el rnetodo que se usa nonnalrnente durante cualquier licencia con goce de sueldo.

En todos los casos, una licencia con o sin goce de sueldo en virtud de FMLA sera tratada de la rnisrna rnanera y en concordancia con una licencia con o sin goce de sueldo no relacionada con FMLA.

10. ;,Se aplican limitaciones a los empleados altamente remunerados?

Segun el Codigo de Irnpuestos Internos, los "ernpleados altamente rernunerados" y los "empleados clave" generalmente son Participantes que son funcionarios, accionistas o altarnente remunerados. El Adrninistrador le notificara cada Aiio del plan si es un

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"empleado altamente remunerado" o un "empleado clave".

Si se encuentra dentro de estas categorias, el monto de las contribuciones y los beneficios para usted podrian verse limitados para que el Plan en su conjunto no favorezca injustamente a aquellos que estan muy bien pagados, sus conyuges o sus personas a cargo. Estas disposiciones tambien se aplican si su Empleador realiza contribuciones a traves de! Plan en su nombre.

Sus propias circunstancias determinaran si se aplicaran limitaciones a las contribuciones de los "empleados altamente remunerados" ode los "empleados clave". Se le notificara de estas limitaciones si se ve afectado.

11. ;,Que sucede si cesa el empleo?

Si deja de trabajar para nosotros durante el Ano del plan, seguira cubierto por el seguro, pero solo durante el periodo por el que se pagaron las primas antes de su renuncia al empleo. Cualquier monto que no se utilice durante un Ano del plan para proporcionar beneficios se perdera y no se le podra pagar en efectivo ni se utilizara para brindar beneficios especificamente para usted en un Ano del plan posterior.

Si esta inscrito en una Cuenta de Ahorros para la Salud y esta hacienda contribuciones a traves del Plan, cualquier monto no utilizado dentro de su HSA seguira estando a su disposicion para ser retirado para pagar gastos calificados exento de impuestos, o podra serle entregado, sujeto a las pautas aplicables de! IRS o los terminos de su cuenta HSA. Debe comunicarse con el administrador de la HSA para analizar cualquier pregunta relacionada con los derechos que pueda tener sobre los montos no utilizados retenidos en su cuenta de ahorros para la salud al momenta del cese del empleo.

12. ;,Que es una cuenta de ahorro para la salud?

Ademas del Premium Only Plan, descrito anteriormente, este Plan tambien puede prever que usted haga contribuciones (mediante deduccion de nomina) antes de impuestos a una "Cuenta de ahorros para la salud" (tambien conocida como "Programa HSA"). La HSA es un nuevo tipo de cuenta que permite a quienes eligen participar en este programa pagar los gastos medicos elegibles de la HSA o permitir la distribucion de los saldos restantes para otros fines que cumplan con los requisitos. El Programa HSA, si corresponde, se proporciona y administra por separado a traves de un Administrador de HSA o una cuenta de custodia similar. La eleccion de su Empleador de permitirle hacer contribuciones al Programa HSA simplemente le brinda la oportunidad de aportar dichos montos a traves de este Plan antes de impuestos.

En general, a menos que sean excluidos de la participacion, todos los Participantes del Premium Only Plan son elegibles para recibir beneficios de este Programa HSA, siempre y cuando sean elegibles para participar en el Premium Only Plan. Las condiciones de inscripcion y cancelacion del Premium Only Plan generalmente constituiran tambien la inscripcion y cancelacion de la participacion en este Programa HSA. Ademas, otros asuntos relacionados con contribuciones, elecciones y similares se regiran por las disposiciones generales del Premium Only Plan; si su Empleador opta por permitirle hacer contribuciones a traves de este Plan a su plan HSA, usted elige el monto que se retirara de su salario de la misma manera que se establecio anteriormente. Su empleador tambien puede optar por hacer contribuciones a su plan HSA, de forma discrecional y de acuerdo con las limitaciones generates del Plan sobre la posibilidad de contribuciones del empleador en general (NOTA: debe comunicarse con el Administrador de HSA para cualquier otra pregunta que pueda tener sobre la elegibilidad para establecer o participar en una HSA, que beneficios se pueden recibir a traves de la participacion en dicho programa y como se utilizan los montos aportados a la HSA para pagar los gastos calificados en virtud de su programa).

Una vez cumplidos los requisitos y elegido, el Administrador establecera una Cuenta de Ahorros para la Salud para cada persona que elija aplicar los montos aportados al Programa HSA establecido o proporcionado por su Administrador de HSA. (NOTA: debe comunicarse con el administrador de la HSA para obtener mas informacion sobre el monto que puede contribuir por ano. El administrador de su HSA le proporcionara mas informacion sobre los requisitos para participar en el programa HSA y los beneficios a \os que tiene derecho en virtud de\ presente. En la medida de cualquier conflicto entre los tenninos de este Plan y el prograrna HSA en el que esta participando, en la medida de su HSA, prevaleceran los tenninos de su HSA.) No somos responsables de las decisiones y operaciones del Administrador de HSA en la administracion de su HSA.

13. Orden de cobertura medica infantil calificada

Una orden de cobertura medica infantil es un fallo, sentencia u orden (incluida la aprobacion de un acuerdo de liquidacion de sociedad conyugal) ernitido en virtud de la legislacion estatal que establece la rnanutencion de los hijos o cobertura rnedica para el hijo de un participante. El hijo se convierte en un "beneficiario alternativo" y puede recibir beneficios de los planes de salud del Ernpleador, si se determina que la orden es "calificada." Puede obtener, sin cargo, una copia de los procedimientos que rigen la determinacion de las ordenes de cobertura rnedica infantil calificadas del Adrninistrador del Plan.

14. Resumen

El dinero que gana es importante para usted y su familia. Lo necesita para pagar sus facturas, disfrutar de actividades recreativas y ahorrar para el futuro. Nuestro plan de beneficios de prirnas lo ayudara a conservar una mayor parte del dinero que gana porque reduce el monto que paga en impuestos. El Plan es el resultado de nuestros continuos esfuerzos por encontrar formas de ayudarlo a aprovechar al maxirno sus ingresos.

Si tiene alguna pregunta, cornuniquese con el Adrninistrador.

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Annual Non-Discrimination Tests

Test 1—Eligibility Test
Lilly Enterprises Inc
Plan Year Ending December 31, 2025

List all employees who fit into one or more of the following categories. An employee may be classified as highly compensated on the basis of more than one category. When listing highly compensated employees, list each employee only once.

1. List all employees who, for the *preceding* year (or the current year in the case of the first year of employment), are officers.	*Kevin Lilly* *Jeaneane Lilly*
2. List all employees with more than 5% ownership, at any time during the *current* or *preceding* plan year.	
3. List all employees who, for the *preceding* plan year (or the current plan year in the case of the first year of employment) had compensation in excess of $100,000 (indexed*)	
4. List all employees who, during the *current* plan year, are the spouse or tax dependent of a highly compensated employee listed above.	

Now answer "Yes" or "No" to the following questions as they relate to the highly compensated employees listed above.

Are all employees, regardless of their location, and part-time employees (if eligible for your plan), allowed to participate in your POP utilizing the same waiting period?	YES	
Are all employees who have worked for your company more than three years eligible to sign up for the POP?	YES	
Once eligible, may employees' sign up for the plan at their next open enrollment?	YES	
Are all the same underlying accident and/or health insurance plans available to both highly compensated and non-highly compensated employees?	YES	

Based on Yes/No answers above PASS

Conclusion: If you answered 'Yes' to all these questions, you can generally skip both the Contributions and Benefits Tests (Test 2 of 4, and 3 of 4) and the 25% Concentration Test (Test 4 of 4).

Please save a copy for Your Records

*see Updated Indexed Compensation Levels for current year amount (Chapter 5)

Discrimination Testing (2025)

For Lilly Enterprises Inc

Section 125 Premium Only Plan

Plan Year Ending December 31, 2025

Overview

Case Studies

Definitions

Updated Indexed Compensation Levels

Testing Procedures

Remedying Discrimination

Annual Discrimination Test #1 Eligibility Test for Lilly Enterprises Inc

Annual Discrimination Test #2 Contributions and Benefits Contributions Test for Lilly Enterprises Inc

Annual Discrimination Test #3 Contributions and Benefits Utilization Test for Lilly Enterprises Inc

Annual Discrimination Test #4 25% Concentration Test for Lilly Enterprises Inc

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Overview — Discrimination Testing

The tax laws impose discrimination restrictions to prevent officers, shareholders and certain highly compensated employees from receiving a disproportionate share of the income tax savings available under POP. In most cases, a POP will not be discriminatory – but it is important to regularly verify that your plan remains nondiscriminatory. If the POP becomes discriminatory, certain plan participants (called highly compensated or key employees under the tax laws) will not be able to exclude their premium payments from their taxable income.

Generally, discrimination is only a problem in very small companies if all the employees are not eligible to participate in the plan. As the employer and plan administrator, it is your responsibility to assess discrimination issues. This chapter is designed to assist you in readily understanding the issues involved. If you need additional assistance, please call us. There will not be an additional charge for this assistance.

This section describes the discrimination rules governing Section 125 Premium Only Plans (POP). The first part of this section provides a brief overview of these rules, and the second part goes into greater detail and includes worksheets that you can use to test whether your POP is discriminatory.

There are four nondiscrimination tests:

1. Eligibility Test (if this test is passed, tests 2, 3 and 4 are not required)
2. Contributions and Benefits Contributions Test
3. Contributions and Benefits Utilization Test
4. 25% Concentration Test

The Safe Harbor Test for POPs

If an employer passes the eligibility test for their POP, they do not have to perform or pass the contributions and benefits tests or the overall 25% concentration test. This is welcome relief for all plan sponsors, but of particular value for smaller employers.

Example **

Assume that XYZ Employer has 100 employees (40 of whom are highly compensated employees; 60 of whom are non-highly compensated employees). XYZ maintains a POP in which 30 non-highly compensated employees participate (30 / 50 = 50%) and 36 highly compensated employees participate (36 / 40 = 90%). The plan's ratio of non-highly compensated employees participating in XYZ's POP compared to the ratio of highly compensated employees participating in XYZ's POP is 50% or greater (i.e., 55.56% = 50% / 90%), meaning the XYZ POP plan has met the "safe harbor test for eligibility" and XYZ Employer does not have to perform the Contributions & Benefits Test or the 25% Concentration Test. Note, however, that XYZ Employer could even pass this safe harbor test with a ratio that is less than 50%; the ratio percentage required to pass gets lower as the number of non-highly compensated employees participating in the POP increases. But, at a very high level, a 50% ratio or greater will pass this safe harbor requirement.

However, if your POP allows employee or employer contributions to a Health Savings Account (HSA) this safe harbor does not apply.

There are generally four questions that must be answered to determine whether a POP is discriminatory.

Question 1: **Does each employee benefit plan included in the POP (and selected under your Adoption Agreement) permit all employees to participate under the same conditions?**

Answer: If the answer is yes, then the POP will be nondiscriminatory on the basis of eligibility to participate.

If the answer is no, the POP is not necessarily discriminatory, but additional testing is required. Please note that all employees of the company and its affiliates must be considered for purposes of determining whether the plan is discriminatory on the basis of eligibility. Additionally, each employee benefit plan is tested separately.

Question 2: **Does each employee benefit plan included in the POP (and selected under the Adoption Agreement) determine contributions and benefits on the same basis?**

Answer: If the answer is yes, then the POP will be nondiscriminatory on the basis of contributions and benefits. For example, if you maintain a group-term life insurance plan that provides the same percent of compensation of coverage for each participating employee, then the POP should be nondiscriminatory as it relates to benefits under the group-term life insurance plan. Additionally, if employees' premiums are determined on the same basis, then the POP should be nondiscriminatory on the basis of contributions. This is the case even if the premiums for life insurance, for example, vary based on employees' ages.

**This example is for illustrative purposes only; any questions regarding the specifics of your plan should be directed to benefits counsel.

Question 3: **Have all eligible employees been offered the opportunity to participate in the POP and convert their premiums to pre-tax contributions?**

Answer: If the answer is yes, then the POP should be nondiscriminatory on the basis of utilization. If the answer is no, the POP could be discriminatory. Call the hotline for further assistance to determine if the POP is discriminatory.

Question 4: **Do "key employees" (another term that is defined later) pay more than 25% of the aggregate annual premiums under all of the employee benefit plans that are included in the POP (and selected under the Adoption Agreement)?**

Answer: If the answer is yes, then those key employees cannot exclude any of their premiums from their taxable income. We will discuss later some steps you can take during the plan year if your key employees pay more than 25% of these premiums.

(Question number 4 is no longer applicable if your POP passed the eligibility test and does not allow for employer or employee contributions to an HSA)

Action may be required: If your POP allows contributions to Health Savings Accounts, you will need to perform all 4 of the nondiscrimination tests.

Case Studies — Discrimination Testing

In the following examples, assume that the cost of individual health coverage is $150 per month; family coverage is an additional $300 per month.

Ace Auto Sales, Scenario #1

A is the principal owner of Ace Auto Sales. His sons, B and C, and daughter, D, also work for Ace. A has given each of the children 10% ownership of the dealership. There are nine other employees. Ace Auto Sales is a C corporation.

Ace Auto Sales instituted a POP. Is there a discrimination problem here? All employees are eligible to participate in the POP. The dealership pays all of the health insurance costs for the families of A, B, C and D. Since the principals pay no portion of their premiums, they will *not* be able to make salary redirection to the POP. The remainder of the employees can pay for individual health insurance coverage, or family health insurance coverage through the POP.

In the preceding scenario, only members of the Ace family qualify as key employees by definition (see "Definitions"). These individuals did not elect non-taxable benefits, so discrimination is not a problem.

Ace Auto Sales, Scenario #2

Assume the same set of facts as in scenario #1, except for the following: A and his children have the cost of their insurance premiums deducted from their paychecks. When the POP is installed, the members of the Ace family plan to participate and pay their health insurance premiums on a pre-tax basis. Is discrimination a problem in this case?

The following is an appraisal of the facts and circumstances of this case with an eye toward potential discrimination issues in a POP:

Employee	Percent Ownership	Key Employee	Premium Cost
A	70%	Yes	$450
B	10%	Yes	$450
C	10%	Yes	$450
D	10%	Yes	$450
E			$150
F			$150
G			$450
H			$150
I			$150
J			$150
K			$150
L			$450
M			$150

Case Studies — Discrimination Testing (cont.)

1. Total non-taxable benefits paid to key employees $450 x 4 = $1,800
2. Total non-taxable benefits paid to all other employees ($450 x 2) + ($150 x 7) = $1,950
3. Total non-taxable benefits paid = $3,750 (line 1 + line 2)
4. Percentage of non-taxable benefits paid to key employees = 48% (line 1 / line 3)

Ace Auto Sales Premium Only Plan is discriminatory in that it fails the 25% Concentration Test.* One suggested course of action to remedy this situation would be for the corporation to pay the premiums for all owners, as in scenario #1.

However, if the plan passes the eligibility test for POP, it does not have to perform or pass the contributions and benefits test or the overall 25% concentration tests.

The company would still save $1,872 in payroll taxes without key employee participation. The savings would be computed as follows:

Premium cost (non-key employees)	1,950
Annualized (x 12 months)	x 12
Annual premium	$23,400
Approximate payroll tax rate	8 %
Tax savings to employers	$1,872

Other options are discussed later in this section under “Remedying Discrimination.”

While we do not encounter potentially discriminatory situations in most Premium Only Plans, it is nonetheless prudent to be familiar with the rules, definitions and specific tests which govern discrimination in such a plan.

Should discrimination become an issue for your organization please feel free to call the technical assistance hotline for free assistance.

This test is no longer applicable if your POP passed the eligibility test and does not allow for employer or employee contributions to an HSA)

Definitions — Discrimination Testing

The tax laws contain several rules prohibiting discrimination in a Section 125 Premium Only Plan. If the POP becomes discriminatory, then the highly compensated participants cannot exclude any of their premiums from their taxable income. Additionally, if the key employees contribute more than 25% of the aggregate annual premiums and contributions to an HSA under all of the benefits included in the POP, and the POP does not pass the eligibility test, then those key employees must reduce or eliminate their pre-tax contributions to the POP.
There are two distinct groups of employees that must be identified and tested: highly compensated participants and key employees. In many cases, employees who are considered highly compensated participants will also be considered key employees.

The definition of a Highly Compensated Participant (Code Section 125(e)) means an employee who is participating in the POP and is one of the following:

1. An officer for the preceding year (or the current plan year in the case of the first year of employment).
2. A more than 5% owner at any time during the current or preceding plan year.
3. Had compensation in excess of $xx,xxx (indexed amount**) for the preceding plan year (or the current plan year in the case of the first year of employment).

   [$xx,xx is an indexed amount – please find the current and prior year amounts on the “Updated Indexed Compensation Levels” page that follows.]
4. The spouse or tax dependent of a highly compensated employee listed above.

The definition of a Key Employee (Code Section 414(q)) means an employee who, at any time during the preceding plan year of the POP, was:

1. an officer with compensation in excess of $xxx,xxx (indexed*) [$xxx,xxx is an indexed amount – please find the current and prior year of amounts on the “Updated Indexed Compensation Levels” page that follows];
2. a more than 5% owner of the employer; or
3. a more than 1% owner with compensation in excess of $150,000.

The determination as to whether an employee is an officer should be made on all the facts and circumstances.
Generally, the term “officer” means an administrative executive. According to regulations under 414(q), an officer includes the president, vice-president, general manager, treasurer, secretary and comptroller of a corporation and any other person who performs duties corresponding to those normally performed by persons occupying those positions.
Section 318 family attribution rules will still apply in determining who is a key employee.

For purposes of determining ownership, stock owned by an employee’s spouse, children, grandchildren, or parents is treated as owned by the employee.

Although someone may not actually “own” any stock – by attributing stock to family members, only for nondiscrimination purposes, this ensures that closely held companies do not adversely favor the owners of the employer.

For purposes of identifying officers, no more than 50 employees are treated as officers. Additionally, if there are less than 50 employees who are treated as officers, no more than the greater of three employees or 10% of all employees will be treated as officers.

The definition of key employee is the same definition of key employee that applies for purposes of the “top heavy” rules governing tax qualified retirement plans.

Compensation means an employee’s compensation that is paid during the plan year of the POP and is includable in taxable income. Additionally, salary reduction contributions under the POP or to a 401(k) plan or tax-sheltered annuity must also be included in compensation for purposes of the discrimination rules.

Finally, for purposes of determining ownership of the employer, stock owned by an employee’s spouse, children, grandchildren, or parents is treated as owned by the employee. See Code Section 318 for further information.

See “Updated Indexed Compensation Levels” for current and preceding years’ indexed amounts.

Although someone may not actually “own” any stock – by attributing stock to family members, only for nondiscrimination purposes, this ensures that closely held companies do not adversely favor the owners of the employer.

Updated Indexed Compensation Levels

Updated cost-of-living adjustments will affect the compensation amounts you use when determining which employees are key employees for discrimination testing. The indexed amounts are as follows:

	2023	2024	2025
Highly Compensated	$150,000	$155,000	$TBD
Key Employee, Officers	$215,000	$220,000	$TBD

It is important to determine now who the highly compensated and key employees are so that your Section 125 Premium Only Plan can be reviewed for possible discrimination problems.

Review the Discrimination Testing procedures in this section. The discrimination tests on your Section 125 Plan, based on contributions, must be passed as of the last day of the plan year.

However, to avoid taxing the premiums for Highly Compensated or Key employees at the end of the plan year, we recommend you also conduct preliminary discrimination tests at the beginning of the plan year.

Suggested courses of action to correct a discriminatory plan are discussed later in this section under “Remedying Discrimination.”

For assistance on discrimination testing, please call our technical assistance hotline.

Testing Procedures — Discrimination Testing

This section describes a procedure for determining whether the POP is discriminatory.

To determine whether any employee benefit plan included in the POP discriminates, each employee benefit plan should be tested separately. If employer contributes to a Health Savings Account through this Plan, such contributions are also subject to discrimination testing as otherwise set forth below.

Discrimination is tested on the basis of eligibility and on the basis of contributions and benefits. For purposes of discrimination, you can generally exclude employees who are covered by a collective bargaining agreement. Additionally, if the POP benefits only collectively bargained employees, it is automatically considered to be nondiscriminatory, and no testing should be required.

Step 1 Eligibility

1. Eligibility. The requirements for participation in a POP must not discriminate in favor of highly compensated employees. In other words, may all employees enter your POP under the same conditions?
2. Participation. An employee who satisfies any conditions for participation must be permitted to elect to participate in the POP no later than the first day of the plan year immediately following the date the employee became eligible for the POP. But in no case can the requirements for participation withhold enrollment in the plan beyond three years of employment.

   Your POP is written to allow employees to enter the plan when they become eligible for your employer-sponsored accident or health plans.
3. Benefits. Different benefits may not be offered to your highly compensated participants and your non-highly compensated participants. Example: If a low-deductible health plan is offered to just highly-compensated employees and a high-deductible health plan is offered to all non-highly compensated employees – the plan would fail the eligibility test. Even if the same accident and health plan is offered to all employees, but unequal premium contribution amounts are established for each group, the plan would not pass the eligibility test.

The Contribution and Benefits Test (Step 2) is no longer applicable if your POP passed the Eligibility Test and HSA contributions are NOT a part of your POP

Step 2 Contributions and Benefits

If you have verified that the POP is discriminatory as to eligibility, you must test whether the plan ensures that similarly situated highly compensated and non-highly compensated employees have a uniform opportunity to elect qualified benefits, or to receive employer contributions; and the actual elections are not made disproportionately by highly compensated employees.

An employee benefit plan is tested for discrimination on the basis of contributions and benefits by reference to the normal rules governing discrimination for that plan under the Code.

For example, a group-term life insurance plan is nondiscriminatory on the basis of benefits if the plan satisfies the rules under Code Section 79(d). Under Code Section 79(d), a group-term life insurance plan is tested for discrimination by reference to key employees (as defined earlier).

Suppose a company's plan provides a death benefit equal to the same percent of compensation for all covered participants. That plan is nondiscriminatory on the basis of benefits even though key employees receive a greater dollar amount of coverage.

Discrimination under a group-term life insurance plan on the basis of contributions is generally never a problem unless key employees pay a lower premium for reasons relating to their status as key employees. For example, premiums for younger employees are typically less than premiums for older employees. A group-term life insurance plan is not considered discriminatory on the basis of contributions solely because a younger key employee pays a lower premium than an older non-key employee for the same level of coverage.

There are two kinds of health plans for purposes of discrimination: insured plans and self-insured plans. Generally, a plan is insured if the risk of loss under the plan is shifted to someone who is unrelated to the company. Most health plans offered by insurance companies constitute insured plans for this purpose. Conversely, if the company assumes the risk of loss for the benefits under its health plan, that plan is generally considered self-insured for this purpose.

If an employer partially insures and partially self-insures benefits, or if there is an arrangement such as a minimum premium arrangement with an insurance company, you should call the hotline for assistance.

A self-insured health plan is nondiscriminatory if benefits under the plan satisfy the rules under Code Section 105(h). Under Code Section 105(h), discrimination is tested by reference to highly compensated individuals (a term defined under Code Section 105(h)).

There are no rules under the Code prohibiting discrimination under a fully insured plan. Consequently, there are no rules under the Code to determine whether a fully insured health plan is discriminatory. Nevertheless, if benefits under a fully insured health plan are not available to all employees on the same terms and conditions, then the POP could be considered discriminatory as it relates to the health plan. The same benefits or employer contributions must be made available to similarly situated highly compensated and non-highly compensated employees on a nondiscriminatory basis.

A health plan (whether insured or self-insured) is generally nondiscriminatory on the basis of contributions if employees' premiums are not determined by reference to employees' status as highly compensated participants (in the case of fully insured plans) or highly compensated individuals (in the case of self-insured plans).

Once you have verified that the POP is nondiscriminatory as to availability, you must test whether all highly compensated participants and all non-highly compensated participants have elected to participate in the POP and convert their premiums to pre-tax contributions. This is called the Utilization Test. If less than all participants elect to convert their premiums, the POP could be discriminatory. Simply because the employee benefits plans included in the POP are nondiscriminatory, this does not automatically mean that the POP will be nondiscriminatory.

The 25% Concentration Test (Step 3) is no longer applicable if your POP passed the Eligibility Test and HSA contributions are NOT a part of your POP

Step 3 You Must Complete Step 3 if HSA Contributions are Included in Your POP

If you have verified that the POP is discriminatory as to eligibility, you must test whether key employees contribute more than 25% of the aggregate premiums and employee and employer contributions to an HSA under all of the employee benefits included in the POP. This test is made on the basis of premiums and employee and employer contributions to an HSA contributed during the POP plan year. Additionally, this test is made on the basis of premiums paid under all employee benefits and not on a benefit-by-benefit basis.

This 25% test (generally called the Concentration Test) is not so much a discrimination test as much as it is a limit on the amount of tax savings that the POP can provide to key employees. For ease of administration, however, we include the Concentration Test in this section.

The Concentration Test is relatively straightforward and is demonstrated elsewhere in this section.

Remedying Discrimination

This section discusses steps you can take if you determine that a POP may be discriminatory or if it fails the Concentration Test. Before you establish a POP you should verify that the plan will not be discriminatory and fail the Concentration Test. Each year thereafter you should verify that the POP continues to be nondiscriminatory and satisfies the Concentration Test.

The purpose of the POP is to exclude premiums that employees pay for benefits from their income for purposes of income taxes and FICA. If the POP is discriminatory, highly compensated participants must continue to include their premiums in income.

Additionally, if aggregate premiums paid by key employees exceed 25% of aggregate premiums paid by all employees, then the key employees must include their premiums in income. All other employees, however, continue to exclude their premiums from income.

Since you save FICA taxes on all premiums that are excluded from income, they will be best served by maintaining the POP and taking corrective steps if the plan becomes discriminatory or fails the Concentration Test.

What should you do if the POP is or becomes discriminatory or fails the Concentration Test?

The company may reduce the key employees' contributions to the plan until the 25% Concentration Test is successfully passed.

One alternative is to simply exclude all of the highly compensated participants (if the POP is discriminatory) or exclude all of the key employees (if the POP fails the Concentration Test) from participating in the Plan. The remaining employees will continue to enjoy the tax benefits of the POP, and the company will continue to save FICA taxes on the premiums of participants.

Alternatively, the company could pay the highly compensated participants' or the key employees' premiums and then exclude these employees from participating in the POP. In this case, since the highly compensated employees and/or key employees are not paying premiums, there is no reason for them to participate in the POP.

If the plan is nondiscriminatory but fails to satisfy the Concentration Test, an alternative is to exclude some or all of the key employees from participating in the plan. This alternative could raise discrimination questions under other laws. Consult with an attorney before adopting this alternative.

Another alternative is to eliminate the discriminatory features of the employee benefit plan that causes your POP to be discriminatory. Call the hotline for ways to make an employee benefit plan nondiscriminatory. You should also consult with the insurance company insuring benefits under the discriminatory employee benefit plan to verify the effects of changing the terms of the existing insurance policy.

Notes: