

SCOTT COUNTY

HEALTH CARE EXPENSE ACCOUNT AND DEPENDENT CARE ASSISTANCE PROGRAM PLAN

SUMMARY PLAN DESCRIPTION

June 01, 2019

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INTRODUCTION

Scott County (the "Employer") established the Scott County Health Care Expense Account and Dependent Care Assistance Program Plan (the "Plan") effective March 01, 1987. This summary describes the Plan as amended and restated effective June 01, 2019. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Employer and any employer who has adopted the Plan is referred to in this document as the "Employer".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the Employer or any affiliate who has adopted the Plan. The age and service requirements for the Plan are further modified by the following: You and your dependents are eligible for Scott County benefits the first of the month on or after your date of hire.

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- A part-time employee who is expected to work fewer than working less than 50% hours per week.
- Those employees not classified as a permanent or probationary Employee who is working a FTE of 50% and greater or persons not covered by a collective bargaining agreement or a County policy which provides for inclusion of such persons in the Plan.

If you are eligible to participate in the Employer-sponsored group health plan, then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Employer-sponsored group health plan.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you must submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan

Year.

If you fail to submit an election form, prior year elections will automatically apply to the following benefits: Premium Conversion Account. An election to participate in the Plan is generally irrevocable for the Plan Year. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.
- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Employer, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

Premium Conversion Account

The Plan will automatically establish a Premium Conversion Account in your name when you become an Employee for the payment of premiums under the Employer-sponsored benefits/contracts listed below unless you affirmatively elect to not establish or contribute to such account. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- Employer Health
- Employer Dental

- Employer Vision
- Employer Group Term Life

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Employer as permitted by applicable law.

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes, except that contributions for the payment of premiums under Employer Group Term Life Insurance will be made on an after-tax basis to the extent that the premiums relate to coverage in excess of \$50,000.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Employer-sponsored group health plan, then you are not eligible to participate in a Health FSA.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted by Federal Law under the tax code (\$2,700 for 2019). The minimum annual contribution for participation in your Health FSA is: \$130. The Employer will not make additional contributions to your General Purpose Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. The Plan Administrator may direct reimbursement only up to the balance in your Health FSA at the time you submit reimbursement request to the Plan Administrator.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA. Medicines or drugs are eligible expenses only if the medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded).

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

You must submit claims for reimbursement from your Health FSA no later than 105 days after the end of the Plan Year. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

General Purpose FSA Grace Period and Runout Period

Any amounts remaining in your General Purpose Health FSA at the end of the Plan Year may be used for expenses that you incur during the Grace Period. The Grace Period is the time frame from the end of the plan year (July 31st) to October 15th of each year. You have an additional 30 days (the Runout Period) after the Grace Period ends to submit any claims for expenses incurred prior to the end of the Plan Year or the Grace Period. Any amounts remaining in your General Purpose Health FSA at the end of the Grace Period and Runout Period after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 105 days after the end of the Plan Year in which your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Qualified Reservist Distributions

If you are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may elect to receive a distribution from your Health FSA up to an amount equal to the entire amount you elected for the applicable FSA for the Plan Year, minus reimbursements paid as of the date of the distribution request. You must make the distribution request during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted per Federal Law under the tax code (\$5,000 for 2019, \$2,500 if you are married and filing separately.) The minimum contribution for participation in your DCAP Account is: \$130.

The Employer will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Plan Administrator or Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 105 days following the Plan Year. Any amounts remaining in your DCAP Account at the end of the Plan Year after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 105 days after the end of the Plan Year in which your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to the Plan Administrator at:

Address: 730 2nd Avenue South Suite 400, Minneapolis, Minnesota 55402
Phone number: 800-300-1672

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

To the extent that the Plan Administrator approves a claim, the Employer may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan

Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering

the appeal, the Plan Administrator will:

- (A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;
- (B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and
- (D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Benefits Provided under Contracts. Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

Debit/Credit Cards

Scott County will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to use the cards and may request reimbursements as listed above.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Employer is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs 20 or fewer employees, but you should contact the Plan Administrator who can inform you if the Employer is a small employer not subject to COBRA and is not

required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice of your right to elect COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualified Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the

date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Health FSA to any of its employees.

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Employer may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Employer intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Minnesota to the extent not pre-empted by Federal law.

PLAN INFORMATION

1. The Plan Administrator is 121 Benefits.
2. The Plan Sponsor's Address is 200 Fourth Avenue West, Shakopee, Minnesota 55379.
3. The Plan Sponsor's EIN is 41-6005892.
4. The Plan Sponsor's phone number is 952-445-7750.
5. The Plan Administrator's Address is 730 2nd Avenue South Suite 400, Minneapolis, Minnesota 55402.
6. The Plan Administrator's phone number is 800-300-1672.
7. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.
8. The Plan number is 505.
9. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.
10. The Plan Year is the 12-consecutive month period ending on July 31.
11. Amount contributed by Plan Participants and the Employer to the Plan are general assets of the Employer. All payments of benefits under the Plan are made solely out of the general assets of the Employer. The Employer has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Employer may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.