Amendment to USD #394 - Rose Hill Cafeteria Plan

This Amendment to USD #394 - Rose Hill Cafeteria Plan ("the Plan") is adopted by USD #394 - Rose Hill ("Employer"), effective as of October 1, 2020.

The Plan is amended as follows:

A. The **Title Page**, in part, shall read as follows:

Amended Plan Effective October 1, 2020.

B. **Section 1.1, Establishment of the Plan**, the last sentence shall read as follows:

This Plan Document amends the USD #394 - Rose Hill Cafeteria Plan (the "Plan"), which was originally effective on October 1, 1991 (the "Effective Date"). This amended Plan is effective October 1, 2020.

C. **Section 2, General Information** shall read, in part, as follows:

Plan Effective Date	Original Plan Effective Date: October 1, 1991 Amended Plan Effective Date: October 1, 2020

D. The **Glossary**, the listed definitions shall read as follows:

Effective Date of the original Plan shall be October 1, 1991. Effective Date of this amended Plan shall be October 1, 2020.

E. **Health Flexible Spending Account With Carryover Schedule,** the **Health FSA Carryover Amount; Forfeiture Of Account Balance In Excess of Carryover** section shall read as follows:

- **Health FSA Carryover Amount.** Subject to the conditions provided below, a Participant is entitled to carry over a certain Unused **Health FSA** Balance remaining as of the end of a given Plan Year, determined as of 75 days following the end of the Plan Year to pay Health Care Expenses incurred in the succeeding Plan Year.

  The **Health FSA** Carryover Amount allowed shall be the lesser of:

  - The Participant's Unused **Health FSA** Balance remaining; or
  - The maximum carryover limit permitted under health care reform as adjusted for inflation pursuant to Code §125(i).

- A Participant may elect to waive or decline any unused amount of the **Health FSA** Carryover Amount prior to the end of the current Plan Year by providing written notice to the Plan Administrator.

- The Participant shall forfeit all rights with respect to any Unused **Health FSA** Balance in excess of the maximum carryover limit permitted under health care reform as adjusted for inflation pursuant to Code §125(i).

- If a Participant fails to complete a Salary Reduction Agreement within the Open Enrollment Period for the succeeding Plan Year as described in the Elections paragraphs as discussed in Section 5 for the **Health FSA**, the Participant forfeits all rights with respect to any **Health FSA** Carryover Amount from the preceding Plan Year.

- **Use of Forfeitures**. All forfeitures under this Plan shall be used as follows:

    - First, to offset any losses experienced by Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;

    - Second, to reduce the cost of administering the **Health FSA** during the Plan Year or the subsequent Plan Year; and

    - Third, to provide increased Benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with prevailing IRS guidance.

To evidence USD #394 - Rose Hill's adoption of this Amendment to the USD #394 - Rose Hill Cafeteria Plan, USD #394 - Rose Hill has signed this Amendment on this ____ day of _____, 20___.

USD #394 - Rose Hill

By:_____

Its:_____

Attest:_____

Its:_____

Amendment to USD #394 - Rose Hill Cafeteria Plan

This Amendment to USD #394 - Rose Hill Cafeteria Plan ("the Plan") is adopted by USD #394 - Rose Hill ("Employer"), effective as of October 1, 2020.

In response to the IRS Announcement 2021-7 allowing personal protective equipment, such as masks, hand sanitizer, and sanitizing wipes, for the primary purpose of preventing the spread of the Coronavirus Disease 2019 (COVID-19 PPE) as eligible expenses without a prescription on an interim basis, the Plan is amended as follows:

A. The **Title Page**, in part, shall read as follows:

Amended Plan Effective October 1, 2020.

B. **Section 1.1, Establishment of the Plan**, the last sentence shall read as follows:

This Plan Document amends the USD #394 - Rose Hill Cafeteria Plan (the "Plan"), which was originally effective on October 1, 1991 (the "Effective Date"). This amended Plan is effective October 1, 2020.

C. **Section 2, General Information** shall read, in part, as follows:

Plan Effective Date	Original Plan Effective Date: October 1, 1991 Amended Plan Effective Date: October 1, 2020

D. The **Glossary**, the listed definitions shall read as follows:

Effective Date of the original Plan shall be October 1, 1991. Effective Date of the amended Plan shall be October 1, 2020.

E. Effective as of October 1, 2020, **Appendix C, Interim Exceptions—Medical Expenses That Are Reimbursable from the Health FSA** is added to the **Plan Document** as follows:

The Plan Document contains the general rules governing what expenses are reimbursable under the **Health FSA**. This Appendix C, as referenced in the Plan Document, specifies certain expenses that are included under this Plan with respect to reimbursement from the **Health FSA** – that is, expenses that are reimbursable, even if such expenses may not meet the definition of "medical care" under Code §213(d) and may otherwise not be reimbursable under the regulations governing health flexible spending accounts:

- Personal Protective Equipment (PPE) for the primary purpose of preventing transmission of COVID-19, including masks, hand sanitizer, and sanitizing wipes are treated as amounts paid for medical care under Code §213(d) in accordance with IRS Announcement 2021-7.

Guidance. The IRS guidance governing this Plan Amendment may change on one or more occasions. The Plan Administrator will administer this Plan Amendment in accordance with their interpretation of prevailing IRS guidance. Any factual determinations by the Plan Administrator will be made in its sole discretion on a uniform and consistent basis.

F. **Health Flexible Spending Account With Carryover, Eligible Health Care Expenses** Section**,** the **Health Care Expenses** subsection shall read as follows:

- **Health Care Expenses**. Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent covered under the **Health FSA** for medical care, as defined in Code §213(d), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan. Other expenses that may be reimbursable are listed in Appendix C to the Plan Document.

G. **Interim Amendment.** This Amendment provides interim relief under IRS Announcement 2021-7 and is effective until IRS issues guidance rescinding IRS Announcement 2021-7. In that event, this Amendment will automatically terminate as of the last day of the period listed in that guidance and the Plan's terms will revert back to the terms stated in the Plan Document as of October 1, 2020 unless the Plan's terms are subsequently amended in a successive amendment.

To evidence USD #394 - Rose Hill's adoption of this Amendment to the USD #394 - Rose Hill Cafeteria Plan, USD #394 - Rose Hill has signed this Amendment on this ____ day of _____, 2021.

USD #394 - Rose Hill

By:_____

Its:_____

Attest:_____

Its:_____

Cafeteria Plan
for the Employees of
USD #394 - Rose Hill

Plan Document

Amended Plan Date Effective April 1, 2020
Plan Original Effective Date October 1, 1991

USD #394 - Rose Hill has drafted this Plan Document in good faith to comply with the requirements of the Affordable Care Act ("ACA"). However, the regulations and other guidance under ACA in some cases are interim or not yet promulgated. USD #394 - Rose Hill reserves the right to amend this Plan Document, retroactively if deemed necessary, to comply with ACA, regulations, and other guidance promulgated thereunder.

Cafeteria Plan
for the Employees of
USD #394 - Rose Hill

Plan Document

Table of Contents

Section 1
Introduction

1.1 Establishment of the Plan

This Plan Document amends and restates the USD #394 - Rose Hill Cafeteria Plan (the "Plan"), which was originally effective on October 1, 1991 (the "Effective Date"). This amended and restated Plan is effective April 1, 2020.

1.2 Purpose of the Plan

This Plan allows an Employee to participate in one or more of the following Benefit Options:

- **Premium Only Plan; Health Care Premium Reimbursement (POP)** to make pre-tax Salary Reduction Contributions to pay the Employee's share of the premium or contribution for the Health Plan.

- **Health Flexible Spending Account (Health FSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.

- **Dependent Care Flexible Spending Account (DCFSA)** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.

1.3 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under the Code §125 and regulations issued thereunder and shall be interpreted to accomplish that objective.

The **Health FSA** is intended to qualify as self-insured health reimbursement plan under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

The **DCFSA** is intended to qualify as a dependent care flexible spending account under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

Although reprinted within this document, the **Health FSA** and **DCFSA** are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§105 and 129.

1.4 HIPAA Privacy Rules

This Plan is a "covered entity" for the purposes of the Privacy and Security Rules as described in Section 11.

1.5 Capitalized Terms

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this Plan Document or in other relevant Sections. When reading the provisions of the Plan, please refer to the Glossary. Becoming familiar with

the terms defined in this Plan Document and Glossary will provide a better understanding of the procedures and Benefits described.

Section 2
General Information

Name of the Cafeteria Plan	USD #394 - Rose Hill Cafeteria Plan
Name of Employer	USD #394 - Rose Hill
Address of Plan	104 N. Rose Hill Road Rose Hill, KS 67133
Plan Administrator	USD #394 - Rose Hill
Plan Sponsor and its IRS Employer Identification Number	USD #394 - Rose Hill 48-0699028
Named Fiduciary & Agent for Service of Legal Process	USD #394 - Rose Hill
Type of Administration	The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the USD #394 - Rose Hill Cafeteria Plan. This Plan is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. USD #394 - Rose Hill may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
Plan Number	515
Benefit Option Year	The six-month period ending September 30. All future Plan Years will be a twelve-month period ending September 30.
Plan Effective Date	Original Plan Effective Date: October 1, 1991 Amended Plan Effective Date: April 1, 2020
Claims Administrator	Surency Life & Health Insurance Company (Surency)
Address of Claims Administrator	1619 N. Waterfront Parkway Wichita, KS 67206
Plan Renewal Date	October 1
Internal Revenue Code and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of the Internal Revenue Code of 1986 (the "Code") and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.

In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any determination shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this Section.

Section 3
Benefit Options and Method of Funding

3.1 Benefits Offered

Each Employee may elect to participate in one or more of the following Benefit Options:

- **Premium Only Plan; Health Care Premium Reimbursement (POP)** as described in the POP Schedule.
- **Health Flexible Spending Account (Health FSA)** as described in the Health FSA Schedule.
- **Dependent Care Flexible Spending Account (DCFSA)** as described in the DCFSA Schedule.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

3.2 Employer and Participant Contributions

- **Employer Contributions.** The Employer may, but is not required to, contribute to one or more of the Benefit Options. There are no Employer Contributions for the **POP** under this Plan; however, if the Participant elects the **POP** as described in the POP Schedule, the Employer may contribute toward the Health Plan as provided in the respective plan or policy of the Employer.
- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

3.3 Computing Salary Reduction Contributions

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:
  - The annual election for such Benefits payable on a regular basis in the Period of Coverage;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)
- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the **POP**, **Health FSA** or **DCFSA**, as permitted under the Plan, the Salary Reductions will be calculated as follows:
  - An amount equal to:
    - The new annual amount elected pursuant to the Method of Timing and Elections section below;

        - Less the aggregate Contributions, if any, for the period prior to such election change;
        - Payable over the remaining term of the Period of Coverage commencing with the election change;
    - An amount otherwise agreed upon between the Employer and the Participant; or
    - An amount deemed appropriate by the Plan Administrator. (Example: in the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)

- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for the Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.

- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for the Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.

- **After-Tax Contributions for POP.** After-tax Contributions for the premiums will be paid outside of this Plan.

3.4 **Funding This Plan**

- **Benefits Paid from General Assets.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing in this Plan Document will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as claims payments and enrollment.

- **Participant Bookkeeping Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a bookkeeping account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Plan Benefits. The Plan Administrator will establish and maintain under each Participant's bookkeeping account a subaccount for each Benefit Option elected by each Participant.

- **Maximum Contributions.** The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the **POP** as described in the POP Schedule, **Health FSA** as described in the Health FSA Schedule and **DCFSA** as described in the DCFSA Schedule.

Section 4
Eligibility and Participation

4.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual is regularly scheduled to work 30 or more hours per week and has been employed by the Employer for 0 or more days, counting the Participant's employment commencement date as the first day.

The following classes of employees may not participate in the USD #394 - Rose Hill Cafeteria Plan:

- Leased employees (as defined by §414 (n) of the Code);
- Contract workers and independent contractors;
- Temporary employees, casual employees, and employees hired short-term to meet specific needs of the Employer whether or not such persons are on the Employer's W-2 payroll;
- Individuals paid by a temporary or other employment or staffing agency;
- Employees covered under a collective bargaining agreement;
- Self-employed individuals; and
- Any more than 2% shareholders of S corporations.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

4.2 Required Salary Reduction Agreement

To participate in the Plan, an Employee must complete a Salary Reduction Agreement by the methods set forth in Section 5. If an Employee fails to return a Salary Reduction Agreement, the Employee is deemed to have elected cash and will not be allowed to change such election until the next Open Enrollment unless the Employee experiences an event permitting an election change mid-year.

The **POP** will use a negative election method for enrollments subsequent to the initial enrollment. By initially electing to participate in the **POP** the Employee will have also been deemed to have opted in to the **POP** for future plan year enrollments.

The Employee may begin participation on the first of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements or in accordance with the Enrollment requirements each year.

4.3 Termination of Participation

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;

- The termination of this Plan; or

- The date on which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours, or any other reason. Eligibility may continue beyond such date for purposes of COBRA coverage, where applicable as set forth in the respective Schedule attached hereto, as may be permitted by the Plan Administrator on a uniform and consistent basis, but not beyond the end of the current Plan Year.

False or Fraudulent Claims. Without limitation, the Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits under this Plan.

Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms of this Plan. The Benefit Options identified in the **POP** Schedule will terminate as of the dates specified in the applicable insurance plan for each Benefit Option. Reimbursements from the **Health FSA** and **DCFSA** Accounts after termination of participation will be made pursuant to **Health FSA** Schedule for **Health FSA** Benefits and **DCFSA** Schedule for **DCFSA** Benefits.

4.4 Rehired Employees

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within 30 days or less of the date of termination of employment, the Employee will be reinstated with the same elections that the Participant had prior to termination.

If the Employer rehires a former Participant within the same Plan Year, but more than 30 days following termination of employment and the Participant is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire. Notwithstanding the foregoing, the Plan Administrator may limit the **Health FSA** and **DCFSA** salary reduction contributions of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the maximum dollar limits described in the applicable Schedules.

4.5 Eligibility Rules Regarding the Health FSA

An Employee enrolled in a **Health Savings Account (HSA)** is not eligible to enroll in the **Health FSA**.

4.6 FMLA Leaves Of Absence

Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA then to the extent required by FMLA, the Participant will be entitled to continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution

to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:

- With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, including unused sick days and vacation days; or

- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available. Pre-tax dollars may not be used to fund coverage during the next Plan Year.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purpose of paying for his or her Contributions will be equal to the amount withheld prior to the period of FMLA leave.

Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as the **DCFSA** Benefit) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

4.7 **Non-FMLA Leaves of Absence**

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax Contributions while on leave, or with catch-up Contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

4.8 **Participant's Death**

A Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the end of the month in which the Participant ceases to be eligible for the Plan due to death. A Participant may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

4.9 **COBRA**

Under the COBRA rules, as discussed in the Health FSA Schedule, where applicable, the Participant's Spouse and Dependents may be able to continue to participate under the **Health FSA** through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

Check with the Plan Administrator to determine if this Plan is subject to COBRA.

4.10 **USERRA**

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant were still an active Employee. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or

- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enter such Benefits upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to such Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

Section 5
Method of Timing and Elections

5.1 Initial Election

Completing a Salary Reduction Election. An Employee must complete a Salary Reduction Agreement within the election period set forth in the Salary Reduction Agreement, to enroll in the Benefit Options. An election is deemed complete only upon the following:

- The Employee completes, signs, and returns a Salary Reduction Agreement; or
- If provided by the Employer, the Employee uses the electronic system to make elections. Use of an electronic system will be deemed a completed Salary Reduction Agreement.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the first of the month coinciding with or after the date the Employee completes a Salary Reduction Agreement.

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the applicable Benefit Options.

5.2 Open Enrollment

During each Open Enrollment Period, the Plan Administrator shall provide a Salary Reduction Agreement to each Employee who is eligible to participate in the Plan. The Salary Reduction shall enable the Employee to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Employee must complete a Salary Reduction Agreement provided by the Employer to the Plan Administrator on or before the last day of the Open Enrollment Period.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

5.3 Failure To Elect

If an Employee fails to complete a Salary Reduction Agreement within the time described in Sections 5.1 and 5.2, then the Employee will be deemed to have elected to receive his or her entire Compensation in cash.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or
- Until an event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.

Section 6
Irrevocability of Elections and Exceptions

6.1 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this Section.

Guidance. The rules regarding irrevocability of elections and exceptions are quite complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance. Any factual determinations by the Plan Administrator will be made in its sole discretion on a uniform and consistent basis.

6.2 Procedure for Making New Election If Exception to Irrevocability Applies

- **Timing for Making New Election if Exception to Irrevocability Applies**. A Participant may make a new election within 30 days of the occurrence of an event described in Section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Health Plan shall automatically result in a corresponding election change, whether or not requested.

- **Effective Date of New Election**. Elections made pursuant to this Section shall be effective on the first of the month following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.

- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document, provided that a Participant may not elect to have **Health FSA** or **DCFSA** Salary Reduction contributions in excess of the maximum dollar limits described in the applicable Schedules.

- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the Health FSA or **DCFSA** also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated as described in the applicable Schedules.

6.3 Change in Status Defined

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events

described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under prevailing IRS guidance and under this Plan:

- **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation, or annulment;

- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the **DCFSA**, a change in the number of Qualifying Individuals as defined in Code §21(b)(1);

- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse, or Dependents:

    - A termination or commencement of employment;

    - A strike or lockout;

    - A commencement of or return from an unpaid leave of absence;

    - A change in worksite; or

    - A change in an individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;

- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and

- **Change in Residence.** A change in the place of residence of the Participant, Spouse, or Dependent.

6.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit Option.

The following rules shall apply to all Benefit Options except where expressly limited below.

- **Open Enrollment Period.** A Participant may change an election during the Open Enrollment Period.

- **Termination of Employment**. A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.

- **Leave of Absence**. A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.

- **Change in Status**. *(Applies to the **POP**, **Health FSA** and **DCFSA** as limited below.)* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds to a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer. This rule is referred to as the general consistency requirement.

  A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

  The Plan Administrator, on a uniform and consistent basis, shall determine whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

  - **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, a Spouse or Dependent's death, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health coverage for:

    - The Spouse involved in the divorce, annulment, or legal separation;
    - The deceased Spouse or Dependent; or
    - The Dependent that ceased to satisfy the eligibility requirements.

    Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

    Notwithstanding the foregoing, if the Participant, Spouse, or Dependent becomes eligible for COBRA or similar health plan continuation coverage under the Employer's plan, then the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.

  - **Gain of Coverage Eligibility Under Another Employer's Plan.** When a Participant, Spouse, or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, the Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

  - **Special Consistency Rule for DCFSA Benefits.** With respect to the **DCFSA**, the Participant may change or terminate the Participant's election upon a Change in Status if:

- Such change or termination is made on account of and corresponds to a Change in Status that affects eligibility for coverage under an Employer's plan; or

- The election change is on account of and corresponds to a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.

- **Reduction of Hours Below 30 Hours Per Week With or Without Loss of Eligibility.** (*Applies to the **POP** only.*) If a Participant who was reasonably expected to average at least 30 hours per week experiences a change in status such that the Participant will reasonably be expected to average less than 30 hours per week, even if the reduction of hours does not result in the Participant's loss of eligibility under the group health plan, the Participant may revoke on a prospective basis a prior election for group health plan coverage that provides minimum essential coverage (as defined in the regulations governing the employer shared responsibility provisions of the ACA) provided that:

    - The election revocation under the group health plan corresponds to the Participant's intended enrollment (and the intended enrollment of a Spouse or Dependent whose coverage ceases under the group health plan due to the revocation) in another plan that provides minimum essential coverage;

    - The new plan coverage is effective no later than the first day of the second month following the month that includes that date that the group health plan coverage is revoked; and

    - The Participant provides the Employer with a reasonable representation that the Participant (and the Participant's Spouse and Dependent) has enrolled or intends to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes that date that the group health plan coverage is revoked.

- **HIPAA Special Enrollment Rights.** (*Applies to the **POP** only.*) If the Participant, the Participant's Spouse or Dependent is entitled to HIPAA special enrollment rights under a group health plan, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds to such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:

    - The Participant, Spouse, or Dependent declined to enroll in group health plan coverage because the Participant, the Participant's Spouse or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

    - The Participant acquired a new Dependent as a result of marriage, birth, adoption, or placement for adoption; or

    - The Employee or Dependents who are eligible, but did not enroll for coverage when initially eligible and:

- The Employee or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or

- The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent shall be considered to be consistent with the special enrollment right. An election change due to birth, adoption, or placement for adoption of a new Dependent may, subject to the group health plan, be effective retroactively for up to 30 days.

- **Special Enrollment/Annual Enrollment in an Exchange Qualified Health Plan.** (*Applies to the **POP** only.*) If a Participant is eligible for a Special Enrollment Period in a Qualified Health Plan (QHP) through a Federally Facilitated Marketplace or State Based Marketplace (individually and collectively referred to as "Exchange") pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or if the employee seeks to enroll in a QHP through a Federally Facilitated Marketplace or State Based Marketplace during the Exchange's open enrollment period, the Participant may revoke a prior election for group health plan coverage that provides minimum essential coverage on a prospective basis provided that:

    - The election revocation under the group health plan corresponds to the Participant's intended enrollment (and the intended enrollment of a Spouse or Dependent whose coverage ceases under the group health plan due to the revocation) in a QHP through an Exchange;

    - The new QHP coverage through an Exchange is effective no later than the day immediately following the last day of the group health plan coverage; and

    - The Participant provides the Employer with a reasonable representation that the Participant (and the Participant's Spouse and Dependent) has enrolled or intends to enroll in a QHP for new coverage that is effective no later than the day immediately following the last day of the group health plan coverage.

- **Certain Judgments, Decrees and Orders.** (*Applies to the **POP** and **Health FSA**, but does not apply to the **DCFSA**.*) If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a Qualified Medical Child Support Order (QMCSO), requires accident or health coverage, including an election for **Health FSA** Benefits for a Participant's Dependent, a Participant may:

    - Change an election to provide coverage for the Dependent provided that the order requires the Participant to provide coverage; or

    - Change an election to revoke coverage for the Dependent if the order requires that another individual provide coverage under that individual's plan and such coverage is actually provided.

- **Medicare and Medicaid.** (*Applies to the **POP** and **Health FSA** as limited below, but does not apply to the **DCFSA***.) If a Participant, Spouse, or Dependent is enrolled in a Benefit and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Health Plan covering the person, and the **Health FSA** coverage may be cancelled, but not reduced. However, such cancellation will not be effective to the extent that it would reduce future contributions to the **Health FSA** to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the **Health FSA** coverage.

- **Change in Cost.** *(Applies to the **POP** and **DCFSA** as limited below, but does not apply to the **Health FSA**.)* For purposes of this Section, "similar coverage" means coverage for the same category of Benefits for the same individuals.

    - **Insignificant Cost Changes.** The Participant is required to increase his or her elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options, and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants' elective Contributions on a prospective basis.

    - **Significant Cost Increases**. If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:

        - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;

        - Revoke the election for that coverage, and instead of the revoked election, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or

        - Terminate coverage going forward if there is no other Benefit Option available that provides similar coverage.

        The Plan Administrator will decide whether a cost increase is significant.

    - **Significant Cost Decreases.** If the Plan Administrator determines that the cost of a Benefit (such as the premium for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:

        - Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective contributions by decreasing Salary Reductions;

- Participants who are enrolled in another benefit package option may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or

- Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator will decide whether a cost decrease is significant.

  - **Limitation on Change in Cost Provisions for DCFSA Benefits.** The above "Change in Cost" provisions apply to **DCFSA** Benefits only if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

- **Change in Coverage.** (*Applies to the **POP** and **DCFSA**, but does not apply to the **Health FSA***.) The definition of "similar coverage" applied in the Change of Cost provision above also applies here.

  - **Significant Curtailment.** Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is "significantly curtailed," Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator will decide whether a curtailment is "significant," and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.

    - **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Option (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Option, if offered, that provides similar coverage.

    - **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit Option that provides similar coverage or drop coverage if no other Benefit Option providing similar coverage is offered by the Employer.

    - **Definition of Loss of Coverage.** For purposes of this Section, a "Loss of Coverage" means a complete loss of coverage. In addition, the Plan Administrator may treat the following as a Loss of Coverage:

      - A substantial decrease in the health care providers available under the Benefit Package Plan;

      - A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant, Spouse, or Dependent is currently in a course of treatment; or

- Any other similar fundamental loss of coverage.

- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:

  - Participants who are enrolled in a Benefit Option other than the newly-added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and

  - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator will decide whether there has been an addition of, or a significant improvement in, a Benefit Option.

- **Loss of Coverage Under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, Spouse, or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following:

  - A Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act;

  - A health care program of an Indian Tribal government (as defined in Code §7701(a)(40)), the Indian Health Service, or a tribal organization;

  - A state health benefits risk pool; or

  - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.

- **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds to a change made under an employer plan, including a plan of the Employer or a plan of the Spouse's or Dependent's employer, so long as:

  - The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under prevailing IRS guidance; or

  - The Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan.

  The Plan Administrator will decide whether a requested change is because of, and corresponds to, a change made under the other employer plan.

- **Change in Dependent Care Service Provider**. A Participant may make a prospective election change that corresponds to a change in the dependent care service provider. For example:

- If the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

- If the Participant terminates a dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section must do so in accordance with the procedures described in this Section.

6.5 **Election Modifications Required by Plan Administrator**

The Plan Administrator may require, at any time, any Participant or class of Participants to amend their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;

- Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of a Benefit as provided for under the terms of this Plan than would otherwise be recognized;

- Maintain the qualified status of any Benefit received under this Plan; or

- Satisfy any of the Code's nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans.

In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section 7
Appeals

7.1 Claims Under the Plan

If a claim for reimbursement under the Plan is wholly or partially denied, or if the Claimant is denied a Benefit under the Plan regarding the Claimant's coverage under the Plan, then the appeals procedure described below will apply.

7.2 Notice from Surency

If a claim is denied in whole or in part, Surency will notify the Claimant in writing within 30 days of the date that Surency received the claim. This time may be extended for an additional 15 days for matters beyond the control of Surency, including cases where a claim is incomplete. Surency will provide written notice of any extension, including the reason(s) for the extension and the date a decision by Surency is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Claimant at least 45 days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal Surency's Adverse Benefit Determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information.

7.3 First Level Appeal to Surency

If a claim is denied in whole or in part, the Claimant, or the Claimant's Authorized Representative, may request a review of the Adverse Benefit Determination upon written application to Surency. The Claimant, or the Claimant's Authorized Representative, may request access to all relevant documents in order to evaluate whether to request review of an Adverse Benefit Determination and, if review is requested, to prepare for such review.

An appeal of an Adverse Benefit Determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the Adverse Benefit Determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be given to the initial determination.

7.4 **Surency Action on Appeal**

Surency, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. Surency may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal Surency's Adverse Benefit Determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information.

7.5 **Second and Final Level Appeal to the Plan Administrator**

If the decision on review affirms Surency's initial denial, the Claimant may request a review of the adverse appeal determination upon written application to the Plan Administrator.

The Claimant, or the Claimant's Authorized Representative, may request access to all relevant documents in order to evaluate whether to request review of an Adverse Benefit Determination and, if review is requested, to prepare for such review.

An appeal of an adverse appeal determination must be made in writing within 180 days after receipt of the notice that the first level appeal was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the Adverse Benefit Determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be given to the initial determination.

7.6 **Plan Administrator Action on Appeal**

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the decision on review;

- The specific Plan provision(s) on which the decision is based; and

- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

7.7 **Appeal Procedure for Eligibility or Salary Reduction Issues**

If the Claimant is denied a Benefit under the Plan due to questions regarding the Claimant's eligibility or entitlement for coverage under the Plan or regarding the amount the Claimant owes, the Claimant may request a review upon written application to the Plan Administrator.

The Claimant, or the Claimant's Authorized Representative, may request access to all relevant documents in order to evaluate whether to request review of an Adverse Benefit Determination and if review is requested, to prepare for such review.

An appeal of an Adverse Benefit Determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the Adverse Benefit Determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be given to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;

- The specific Plan provisions on which the decision is based;

- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- Appropriate information on the steps to take to appeal the Plan Administrator's Adverse Benefit Determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information.

Section 8
Plan Administration

8.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with the terms of the Plan document and for the exclusive benefit of persons entitled to participate in this Plan and without discrimination among them.

8.2 Powers of the Plan Administrator

The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions as provided for under the terms of this Plan. The Plan Administrator shall have final discretionary authority to make such decisions and all such determinations shall be final, conclusive, and binding. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters as provided for under the terms of this Plan. The Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;

- To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

- To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

- To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

- To furnish each Employee and Participant with such reports in relation to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide Benefits under this Plan;

- To receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and Benefit consultants;

- To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

- To secure independent medical or other advice and require such evidence as deemed necessary to decide any claim or appeal; and

- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

8.3 **Reliance on Participant, Tables, etc.**

The Plan Administrator may rely upon the Participant's direction, information, or election as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by the Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

8.4 **Outside Assistance**

The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries, and any other person, as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, claims administrators, consultants, actuaries, any other person, and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Plan Administrator.

8.5 **Insurance Contracts**

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan, but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer Contributions toward such insurance.

8.6 **Fiduciary Liability**

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

8.7 **Compensation of Plan Administrator**

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

8.8 **Inability to Locate Payee**

If the Plan Administrator is unable to make payment to the Participant or another person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or such other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to the Participant or such other person shall be turned over to the applicable state's unclaimed property fund five years after the date any such payment first became due.

8.9 **Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the Participant's account, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code §125 or prevailing IRS guidance, correct by making the appropriate adjustments of such amounts as necessary to credit the Participant's account, such other person's account, or withhold any amount due to the Plan or the Employer from Compensation paid by the Employer.

Section 9
Amendment or Termination of the Plan

9.1 Right to Amend

Except as otherwise required by law, the Employer reserves the right to amend, alter, or wholly revise this Plan Document, prospectively or retrospectively, at any time, and the interest of each Participant is subject to the powers so reserved. The Employer expressly may amend, alter, or wholly revise this Plan Document if it determines it necessary or desirable, with or without retroactive effect, to comply with the law. Such changes shall not affect any right to Benefits that accrued prior to such amendments. Such amendment or restatement shall be made in writing and duly executed by an officer or executive authorized by the Employer to do so. After such amendment or restatement is duly executed, such amendment or restatement shall be delivered promptly to the Claims Administrator and Plan Administrator. No Participant has a vested right to Benefits under this Plan.

9.2 Right to Terminate

Except as otherwise required by law, the Employer reserves the right to terminate the Plan and/or any portion of the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor of the Employer. Such termination shall not affect any right to Benefits that accrued prior to such termination. Such action shall be made in writing and shall be delivered promptly to the Claims Administrator and Plan Administrator. No Participant has a vested right to Benefits under this Plan.

Section 10
General Provisions

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures, if any, to the extent provided in the applicable Schedules and then by the Employer.

10.2 No Contract of Employment

Nothing contained in the Plan shall be construed as a contract of employment with the Employer or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee, with or without cause.

10.3 Compliance with Federal Laws

The Plan will provide Benefits in accordance with the requirements of all applicable federal laws, including the Code, COBRA, ACA, HIPAA, and HITECH. In the event of any conflict between any part, clause, or provision of this Plan and such federal laws, where applicable, the provisions of the applicable federal laws shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.4 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee, Spouse, or Dependent. If the Participant does not supply the requested information within the applicable time limits or provide a release for such information, the Participant will not be entitled to Benefits under the Plan.

10.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected with the Employer, except as provided by law; or

- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provided in this Plan Document or as provided by law.

10.6 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

10.7 **Governing Law**

This Plan is intended to be construed, and all rights and duties as provided for under the terms of this Plan Document are governed, in accordance with the laws of Kansas, except to the extent such laws are preempted by other federal law.

10.8 **Severability**

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

10.9 **Captions**

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

10.10 **Federal Tax Disclaimer**

To ensure compliance with requirements imposed by the IRS, to the extent this Plan Document or any Schedule contains advice relating to a federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code or promoting, marketing, or recommending to another party any transaction or matter addressed in this Plan Document.

10.11 **No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer make any commitment or guarantee that any amounts paid to the Participant or for the Participant's benefit under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the Participant's obligation to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.12 **Indemnification of Employer**

If the Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Section 11
HIPAA Privacy and Security

11.1 Provision of Protected Health Information to Employer

For purposes of this Section, Protected Health Information (PHI) shall have the meaning as defined in HIPAA and HITECH. PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased. Electronic Protected Health Information (electronic PHI) means PHI that is transmitted or maintained in electronic media.

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the **Health FSA**, plus any other Benefit Option which might be subject to the privacy and security provisions of HIPAA and HITECH (from now on referred to collectively as the Plan). When this health information is provided to the Employer, it is PHI, and, if it is transmitted by or maintained in electronic media, it is electronic PHI. HIPAA, HITECH, and the respective implementing regulations restrict the Employer's ability to use and disclose PHI and electronic PHI. The Employer shall have access to PHI and electronic PHI from the Plan only as permitted under this Section or as otherwise required or permitted by HIPAA and HITECH.

11.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer information on whether the individual is participating in the Plan.

11.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

Summary Health Information means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom Employer had provided health benefits under a health plan; and

- From which the required information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

11.4 Permitted and Required Uses and Disclosures of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification described below, the Plan may disclose PHI and electronic PHI to the Employer, provided that the Employer uses or discloses such PHI or electronic PHI only for Plan Administration Purposes.

Plan Administration Purposes means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administration

functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI or electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

11.5 **Conditions of Disclosure for Plan Administration Purposes**

Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, the Employer shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions;
- Not use or disclose the PHI to any other employee benefit plans of the Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance with HIPAA's privacy and security requirements;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and the Employer (i.e., the firewall), required by 45 CFR §504(f)(2)(iii) is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic PHI or to interfere with systems operations in an information system containing electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI.

11.6 **Adequate Separation Between Plan and Employer**

The Employer shall designate such employees of the Employer who need access to PHI in order to perform Plan administration functions that the Employer performs for the Plan such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals. No other persons shall have access to PHI. These specified employees, or classes of employees, shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan.

In the event that any of these designated employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

11.7 **Certification of Plan Sponsor**

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 11.5.

11.8 **Organized Health Care Arrangement**

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Option and Health Plan under 45 CFR §160.103 provided by Employer.

Section 12
Glossary

For the purposes of this Plan, including the attached Schedules, the following words and phrases used in this Plan shall have the meaning set forth below unless the words and phrases are defined within a section of this Plan Document. Wherever appropriate, the singular shall include the plural and the plural shall include the singular.

ACA means the Affordable Care Act.

Adverse Benefit Determination means a claim that is denied, in whole or in part, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation.

Authorized Representative means, for the claims and appeal procedures, the person entitled to act on behalf of the Participant with respect to a Benefit claim or appeal. In order for the Plan to recognize a person as an Authorized Representative, written notification to that effect, signed by the Participant and notarized must be received by the Plan. An assignment for purposes of payment is **not** designation of an "Authorized Representative."

Benefit means the Benefit Options offered under this Cafeteria Plan.

Benefit Option means a qualified benefit under Code §125(f) that is offered under this Cafeteria Plan, or an option for coverage under an underlying accident or health plan.

Cafeteria Plan means the USD #394 - Rose Hill Cafeteria Plan as set forth in this Plan Document and as amended and restated from time to time.

Claimant means a Participant, a person designated by a Participant who is entitled to a benefit under the Plan, or an Authorized Representative who submits a Benefit claim or appeal in accordance with the Plan procedures for filing claims or appeals as outlined in this Plan Document.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Code means the Internal Revenue Code of 1986, as amended from time to time.

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to: any Salary Reduction election under this Plan; any Salary Reduction election under any other cafeteria plan; any compensation reduction under any Code §132(f)(4) plan; and any salary deferral elections under any Code §§401(k), 408(k) or 457(b) Plan or arrangement.

Contribution means the amount contributed to pay for the cost of Benefits as calculated under the Benefit Options.

Dependent, with regard to the **POP** and **Health FSA**, means the following individuals as more specifically defined in Code §152 and the guidance promulgated thereunder**:**

- A person who is a qualifying child or qualifying relative;
- Any child of the Participant who as of the end of the taxable year has not attained age 27; and

- Any child of divorced or separated parents who receives more than half of his or her support from one or both parents and is in the custody of one or both parents for more than half of the calendar year.

Generally, the Code does not allow tax-free health coverage for dependents of a Dependent, or married dependents filing joint returns. However, under a special rule, such individuals can still obtain tax-free health coverage, as long as the other Code §152 requirements are met. Likewise, a special rule allows tax-free health coverage for individuals who are a "qualifying relative" even if such individuals have gross income in excess of the exemption amount.

In addition, the **Health FSA** Component will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent, with regard to the **DCFSA**, means a person who is a qualifying person as defined in Code §21, as amended (See also "Qualifying Individual" under the **DCFSA**).

Dependent Care Flexible Spending Account (DCFSA) means the dependent care flexible spending account component established by Employer under the Plan. It allows the Participant to use pre-tax dollars to pay for the care of the Participant's eligible Dependents while the Participant is at work.

Dependent Care Expenses has the meaning described in the **DCFSA** Schedule below.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other compensation, but only if such amounts are includible in gross income for the taxable year. Earned income does not include: any amounts received pursuant to any **DCFSA** established under Code §129; or any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

Effective Date of the original Plan shall be October 1, 1991. Effective Date of this amended and restated Plan shall be April 1, 2020.

Employee means an individual who is regularly scheduled to work for the Employer and meets the criteria provided in Section 4.1.

Employer means USD #394 - Rose Hill (USD #394 - Rose Hill).

FMLA means the Family and Medical Leave Act of 1993, as amended.

Health Care Expenses has the meaning defined in the **Health FSA** Schedule below.

Health Flexible Spending Account (Health FSA) means the health flexible spending account established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for most health expenses not reimbursed under other programs.

Health FSA Carryover Amount means the amount of Unused Health FSA Balance determined as of 75 days after the end of the Plan Year that a Participant can carry over to pay Health Care Expenses incurred in the immediately following Plan Year.

Health Plan means a health benefit plan sponsored by the Employer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and regulations thereunder as amended from time to time.

HITECH means the Health Information Technology for Economic and Clinical Health Act of 2009.

Health Savings Account (HSA) means a Health Savings Account established under Code §223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee or custodian.

Open Enrollment Period with respect to a Plan Year means a period as described by the Plan Administrator preceding the Plan Year during which Participants may make Benefit elections for the Plan Year.

Participant means a person who is an Employee and who is participating in this Plan in accordance with the provisions of the Eligibility and Participation Section. Participants include those that elect to receive Benefits under this Plan, and enroll for Salary Reductions to pay for such Benefits; and those that elect instead to receive their full salary in cash and have not elected the **Health FSA** or **DCFSA**.

Period of Coverage means the Plan Year, with the following exceptions: for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the Eligibility and Participation Section; and for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Eligibility and Participation Section.

Plan means the USD #394 - Rose Hill Cafeteria Plan, as set forth in this Plan Document and as amended from time to time.

Plan Administrator means USD #394 - Rose Hill acting as administrator as defined in ERISA § 3(16)(A).

Plan Year means the six-month period ending September 30. All future plan years will be a twelve-month period ending September 30.

Premium Only Plan (POP); Health Care Premium Reimbursement means the Benefit Option in which an Employee can elect to participate and have Contributions for premiums paid on a pre-tax basis.

Protected Health Information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical, mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

QMCSO means a Qualified Medical Child Support Order.

Qualifying Dependent Care Services has the meaning described in the **DCFSA** Schedule below.

Qualifying Individual means:

- A tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

- A tax dependent of the Participant as defined in Code §152 who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- A Participant's Spouse, as defined in Code §152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code §152(e).

Related Employer means any employer affiliated with USD #394 - Rose Hill that, under Code §414(b), (c), or (m), is treated as a single employer with USD #394 - Rose Hill for purposes of Code §125(g)(4), and which is listed in Appendix A.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefit Options.

Salary Reduction Agreement means the agreement, form, or Internet web site, which Employees use to elect one or more Benefit Options. The agreement and/or forms spell out the procedures used for allowing an Employee to participate in this Plan and will allow the Employee to elect Salary Reductions to pay for any Benefit Option offered under this Plan.

Spouse means an individual who is legally married to a Participant, as determined by the laws of the state or jurisdiction in which the marriage took place, and who is treated as a Spouse under the Code.

Notwithstanding the above, for purposes of the **DCFSA**, the term Spouse shall not include: an individual legally separated from the Participant under a divorce or separate maintenance decree; or an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last 6 months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Student means an individual who, during five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly held.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Unused Health FSA Balance means unused Health FSA amounts remaining at the end of the Plan Year.

To evidence USD #394 - Rose Hill's agreement to this Plan and its terms, USD #394 - Rose Hill has signed this Plan in its name and on its behalf, on this ____ day of _____, 20___.

USD #394 - Rose Hill

By:_____

Its:_____

Attest:_____

Its:_____

Appendix A
Related Employers That Have Adopted This Plan

No Related Employer has adopted this Plan.

USD #394 - Rose Hill is the only employer participating in this Plan.

Appendix B
Exclusions—Medical Expenses That Are Not Reimbursable From the Health FSA

The Plan Document contains the general rules governing what expenses are reimbursable under the **Health FSA**. This Appendix B, as referenced in the Plan Document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the **Health FSA** -- that is, expenses that are *not* reimbursable, even if such expenses meet the definition of "medical care" under Code §213(d) and may otherwise be reimbursable under the regulations governing health flexible spending accounts:

- Effective January 1, 2011, over-the-counter medications or drugs, unless the medicine or drug meets the requirements outlined in Appendix C.
- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee, Spouse, or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for Benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

- Any item that does not constitute “medical care” as defined under Code §213(d).

- Any item that is not reimbursable under Code §213(d) due to the rules in Prop. Treas. Reg. §1.125-2, Q-7(b)(4) or other applicable regulations.

Refer to Appendix C for rules governing the payment or reimbursement of over-the-counter medicine and drugs.

Appendix C
Over-the-Counter Medicine or Drugs and Debit Cards

This Appendix C applies only to the **Health FSA**.

Over-the-Counter Medicine or Drug Requirements for Reimbursement. Effective January 1, 2011, expenses incurred for medicines or drugs may be paid or reimbursed only if the medicine or drug:

- Requires a prescription;
- Is available without a prescription and the individual obtains a prescription; or
- Is insulin.

Prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

The rules do not apply to items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. Such items may qualify as medical care if they otherwise meet the definition of medical care in Section 213(d)(1), which includes expenses for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Expenses incurred for over-the-counter (OTC) medicine or drugs purchased without a prescription before January 1, 2011 may be reimbursed tax-free at any time, pursuant to the terms of the employer's plan.

Monthly Limits on Reimbursing OTC Drugs. Only reasonable quantities of OTC medicines or drugs of the same kind may be reimbursed in a single calendar month (even assuming that the drug otherwise meets the requirements of this Section, including that it has been prescribed (unless it is insulin) and is for medical care under Code §213(d)). Stockpiling is not permitted.

Note: Prior to the purchase of OTC drugs, Participants should verify with the Claims Administrator that the dispensing drug store, pharmacy, or other vendor meets the requirements described below. Failure to do so could result in a debit card not being accepted and the transaction being deemed unsubstantiated.

Debit Cards. Debit cards may not be used to purchase OTC medicines or drugs on or after January 1, 2011 except as provided below:

- **Drug Stores and Pharmacies.** Debit cards may be used to purchase OTC medicines or drugs at drug stores and pharmacies, non-health care merchants that have pharmacies, and mail-order or web-based vendors that sell prescription medicine or drugs if the following requirements are met:
    - Prior to purchase, a prescription is presented to the pharmacist, the OTC drug is dispensed by the pharmacist in accordance with applicable legal requirements, and an Rx number is assigned;

- The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser or patient, and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for debit card programs;

- The records are available to the employer or its agent upon request;

- The debit card system will not accept a charge for an OTC drug unless an Rx number has been assigned; and

- The requirements of other IRS guidance regarding debit card programs are satisfied.

Debit cards also may be used to purchase OTC medicines or drugs at a pharmacy that does not have a SIGIS Inventory Information Approval System (IIAS) if 90 percent of the store's gross receipts during the prior taxable year consist of items which qualify as expenses for medical care under Section 213(d), provided that substantiation is properly submitted.

- **Other Vendors.** Debit cards can be used to purchase OTC drugs from vendors with health care-related merchant category codes (MCCs) if the following requirements are met:

  - The pharmacy or other vendor retains a record of the name of the purchaser or patient and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for debit card programs;

  - The records are available to the employer or its agent upon request; and

  - The requirements of other IRS guidance regarding debit card programs are satisfied.

Debit cards may not be used to purchase OTC drugs at any other providers or merchants after January 15, 2011.

See the following chart for examples of OTC items that do and do not require a prescription for debit card purchases.

Examples of OTC items that require a prescription for debit card purchases:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrhea medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine anti-fungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointments for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies

Examples of OTC items that do not require a prescription for debit card purchases:

- Bandages
- Braces and supports
- Catheters
- Contact lens solution and supplies
- Crutches
- Denture cleaners and adhesives
- Diagnostic tests and monitors (such as blood glucose monitors)
- Elastic bandages and wraps
- First-aid supplies
- Insulin
- Ostomy products
- Reading glasses
- Walkers, wheelchairs, and canes

Schedule A
Premium Only Plan; Health Care Premium Reimbursement

Unless otherwise specified, terms capitalized in this Schedule shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

A.1 Benefits

Under this Premium Only Plan, the Employee may elect the following Benefit Options:

- Health Insurance Premiums
- Dental Insurance Premiums
- Vision Care Insurance Premiums
- Accident Insurance Premiums
- Critical Illness Insurance Premiums

If the Employee is an enrolled participant in the above identified Benefit Options and timely submits an executed Salary Reduction Agreement, the Employee can either:

- Option A: Elect one or more of the Benefit Options under the **POP** by electing to contribute his or her share for the Benefit Options on a pre-tax basis; or

- Option B: Elect no Benefit Options under the **POP** and to contribute his or her share, if any, for the Benefit Options with after-tax deductions outside of this Plan.

If the Employee is a newly enrolled participant in the Health Plan and does not timely submit an executed Salary Reduction Agreement, the Employee will be deemed to have elected Option B.

Benefits elected under Option A will be funded by the Participant's Contributions as provided in the Eligibility and Participation section in the Plan Document.

To determine when a Salary Reduction Agreement will be considered timely submitted, see the Method and Timing of Elections section in the Plan Document.

The **POP** will use a negative election method for enrollments subsequent to the initial enrollment. By initially electing to participate in the **POP** the Employee will have also been deemed to have opted in to the **POP** for future plan year enrollments.

Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section in the Plan Document, such Benefits election is irrevocable for the duration of the Period of Coverage to which it relates.

A.2 Benefit Contributions

The annual Contribution for the **POP** is equal to the amount as set by the Employer, which may or may not be the same amount charged under the Health Plan or the Benefit Options listed above.

A.3 Medical Benefits Provided Under the Health Plan

Benefits will be provided by the Health Plan, not this Plan. The types and amounts of medical benefits, the requirements for participation, and other terms and conditions of coverage and benefits of the Health Plan or Benefits plan are set forth in the documents relating to that plan. No changes can be made under this Plan with respect to such Health Plan if such changes are not permitted under the applicable Health Plan.

All claims to receive benefits under the Health Plan shall be subject to and governed by the terms and conditions of the Health Plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

A.4 COBRA

To the extent required by COBRA, the Participant, Spouse, and Dependent, as applicable, whose coverage terminates under the Health Plan because of a COBRA qualifying event and who is a qualified beneficiary as defined under COBRA, shall be given the opportunity to continue the same coverage that the Participant, Spouse, or Dependent had under the Health Plan the day before the qualifying event for the periods prescribed by COBRA, on a self-pay basis. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Schedule B
Health Flexible Spending Account With Carryover

Unless otherwise specified, terms capitalized in this Schedule shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

B.1 Benefits

An Employee can elect to participate in the **Health FSA** by electing to receive Benefits in the form of reimbursements for Health Care Expenses. If elected, the Benefit Option will be funded by Participant Contributions on a pre-tax Salary Reduction basis and **Health FSA** Carryover Amount, if any, as provided in the Employer and Participant Contributions section in the Plan Document.

Unless an exception applies as described in the Irrevocability of Elections and Exceptions section, such election is irrevocable for the duration of the Period of Coverage to which it relates.

B.2 Benefit Contributions

The annual Contribution for a Participant's **Health FSA** is equal to the annual **Health FSA** Salary Reduction contributions elected by the Participant.

B.3 Eligible Health Care Expenses

Under the **Health FSA**, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred**. A Health Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

- **Health Care Expenses**. Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent covered under the **Health FSA** for medical care, as defined in Code §213(d), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan.

- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the **Health FSA**. Other expenses that are not reimbursable are listed in Appendix B to the Plan Document.

- **Change in Health FSA Benefits for Children Under Age 27.** As a result of a change to the Internal Revenue Code that was part of federal health care reform, a Participant in the **Health FSA** can now be reimbursed for otherwise-eligible Health Care Expenses incurred by a child through December 31 of the calendar year in which the child turns age 26, regardless of the child's residency, employment, financial dependence, student status, marital status, or status as a tax dependent. The change applies to expenses that are incurred on or after March 30, 2010 by a child as defined under the Dependent definition in the Glossary section of this document. Otherwise-reimbursable Health Care Expenses incurred by a child before that date will also qualify

for reimbursement if the child was the Participant's tax dependent for health coverage purposes when the expenses were incurred.

- **Change in Medical Insurance Benefits for Children Under Age 27.** As a result of the change to the Code discussed above, if the Participant has a child who is under age 27 as of the end of the calendar year and is currently receiving health coverage, income will not be imputed for the coverage beginning March 30, 2010.

  If you have questions, please contact the Plan Administrator at USD #394 - Rose Hill.

B.4 Maximum and Minimum Benefits

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum Participant Contribution amount elected by the Participant for reimbursement of Health Care Expenses incurred during a Period of Coverage and the Participant's **Health FSA** Carryover Amount, reduced by prior reimbursements during the Period of Coverage, shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's **Health FSA**. Notwithstanding the foregoing, no reimbursements will be available for Health Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided below.

  Payment shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.

- **Maximum and Minimum Dollar Limits.** For any Plan Year, a Participant may not elect **Health FSA** Salary Reduction contributions in excess of the maximum dollar limit permitted under health care reform as adjusted for inflation pursuant to Code §125(i). The Participant's **Health FSA** Carryover Amount shall not reduce the annual benefit amount eligible for election by the Participant in any Period of Coverage. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be the Participant's **Health FSA** Carryover Amount. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent shall be charged against the Participant's **Health FSA**.

- Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent shall be charged against the Participant's **Health FSA**.

- **Changes**. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document, provided that a Participant may not elect to have **Health FSA** Salary Reduction contributions in excess of the maximum dollar limit permitted under health care reform and described in this Schedule.

- **No Proration**. If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.

- **Effect on Maximum Benefits If Election Change Permitted**. Any change in an election affecting annual Contributions to the **Health FSA** will also change the maximum reimbursement benefits for the balance of the Period of Coverage commencing on the election change effective date. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding:

    - The aggregate Contribution for the period prior to such election change; to

    - The total Contribution for the remainder of such Period of Coverage to the **Health FSA**; to

    - The Participant's **Health FSA** Carryover Amount; reduced by

    - All reimbursements made during the entire Period of Coverage.

- **FMLA Leave.** Any change in an election for FMLA leave will change the maximum reimbursement benefits in accordance with FMLA or the regulations governing cafeteria plans.

B.5 Establishment of Account

The Plan Administrator will establish and maintain a **Health FSA** with respect to each Participant who has elected to participate in the **Health FSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account established under the **Health FSA** will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts**. A Participant's **Health FSA** will be credited 75 days after the end of the prior Plan Year with the **Health FSA** Carryover Amount, if any. A Participant's **Health FSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- **Debiting of Accounts**. A Participant's **Health FSA** will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage.

- **Available Amount Not Based on Credited Amount**. The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this Section above. It is not based on the amount credited to the **Health FSA** at a particular point in time.

B.6 Health FSA Carryover Amount; Forfeiture Of Account Balance In Excess of Carryover

- **Health FSA Carryover Amount.** Subject to the conditions provided below, a Participant is entitled to carry over a certain Unused **Health FSA** Balance remaining as of the end of a given Plan Year, determined as of 75 days following the end of the Plan Year to pay Health Care Expenses incurred in the succeeding Plan Year.

    The **Health FSA** Carryover Amount allowed shall be the lesser of:

    - The Participant's Unused **Health FSA** Balance remaining; or

    - $500.00.

- A Participant may elect to waive or decline any unused amount of the **Health FSA** Carryover Amount prior to the end of the current Plan Year by providing written notice to the Plan Administrator.

- The Participant shall forfeit all rights with respect to any Unused **Health FSA** Balance in excess of $500.00.

- If a Participant fails to complete a Salary Reduction Agreement within the Open Enrollment Period for the succeeding Plan Year as described in the Elections paragraphs as discussed in Section 5 for the **Health FSA**, the Participant forfeits all rights with respect to any **Health FSA** Carryover Amount from the preceding Plan Year.

- **Use of Forfeitures**. All forfeitures under this Plan shall be used as follows:

    - First, to offset any losses experienced by Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;

    - Second, to reduce the cost of administering the **Health FSA** during the Plan Year or the subsequent Plan Year; and

    - Third, to provide increased Benefits or compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with prevailing IRS guidance.

B.7 Unclaimed Benefit Payments

Any benefit payments that are processed, but not cashed within thirteen months of such benefit payment's issue date shall be turned over to the applicable state's unclaimed property fund pursuant to Section 8.8.

Refer to Appendix C for rules governing the payment or reimbursement of OTC medicine and drugs.

B.8 Reimbursement Procedure

- **Timing.** Within 30 days after receipt by the Claims Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Care Expenses or the Claims Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.

- **Claims Substantiation**. A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting a claim to Surency within 75 days of the Period of Coverage, setting forth:

- The person or persons on whose behalf Health Care Expenses have been incurred;
- The nature and date of the expenses incurred;
- The amount of the requested reimbursement;
- The name of the person, organization, or entity to whom the Expense was or is to be paid;
- A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and
- Other such details about the expenses that may be requested by Surency in the reimbursement request form or otherwise.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that Surency may request. Except for the final reimbursement claim for a Participant's **Health FSA** for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25. If the **Health FSA** is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by Surency in accordance with the prevailing IRS guidance.

- **Claims Denied**. For appeal of claims that are denied, see the Appeals Procedure in the Plan Document.
- **Claims Ordering; No Reprocessing.** All claims for reimbursement will be paid in the order in which they are approved. Claims for reimbursement incurred during the current Plan Year will be first paid from unused current year Participant Contributions and then from the **Health FSA** Carryover Amount. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it from amounts attributable to a different Plan Year or Period of Coverage.

B.9 Reimbursements After Termination; Limited COBRA Continuation

When a Participant ceases to be a Participant under Section 4.3, the Participant's Salary Reductions and election to participate as well as the **Health FSA** Carryover Amount will terminate. The Participant will not be able to receive reimbursements for Health Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant or the Participant's estate, may claim reimbursement for any Health Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim within 75 days after the date that the Participant ceases to be a Participant.

Health FSA expenses are reimbursed up to the full amount of the Participant's annual coverage. If the Participant terminates employment and has been reimbursed for more than the amount the Participant contributed to the **Health FSA**, the Participant does not need to repay the overspent amount.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and such Participant's Spouse and Dependent, whose coverage terminates under the **Health FSA** because

of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the **Health FSA** the day before the qualifying event, subject to all conditions and limitations under COBRA. The Contributions for such continuation coverage will be equal to the cost of providing the same coverage to an active employee taking into account all costs incurred by the Employee and the Employer plus a 2% administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining Contribution payments at the time of the qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified if the individual is eligible for COBRA continuation coverage.

If COBRA is elected, COBRA coverage will be subject to the most current COBRA rules. COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the **Health FSA** will cease at the end of the Plan Year and may not be continued for the next Plan Year. Coverage may terminate sooner if the Contributions for a Period of Coverage are not received by the due date established by the Plan Administrator for that Period of Coverage. Continuation coverage is only granted after the Plan Administrator has received the Contributions for that Period of Coverage.

Contributions for coverage for **Health FSA** Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- Because the Employee ceases to be eligible because of a reduction of hours; or
- Because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage.

For all other individuals, Contributions for COBRA coverage for **Health FSA** Benefits shall be paid on an after-tax basis, unless permitted otherwise by the Plan Administrator, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

B.10 Qualified Reservist Distribution

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the **Health FSA**:

- The Participant's Contributions to the **Health FSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **Health FSA** for the Plan Year as of that date.
- The Participant is ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.

- The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009 and continues on or after the date.

- During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant submits a qualified reservist distribution election form to the Plan Administrator.

Amount of Qualified Reservist Distribution. If the above conditions are met, the Participant will receive a distribution from the **Health FSA** equal to the Participant's Contributions to the **Health FSA** for the Plan Year plus the **Health FSA** Carryover Amount, if any, as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

No Reimbursement for Expenses Incurred After Distribution Request. Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the **Health FSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **Health FSA** reimbursements for the Plan Year.

Tax Treatment of a Qualified Reservist Distribution. If the Participant receives a qualified reservist distribution, it will be included in the Participant's gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

B.11 Coordination of Benefits

Health FSAs are intended to pay Benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the **Health FSA** shall not be considered a group health plan for coordination of benefits purposes, and the **Health FSA** shall not be taken into account when determining benefits payable under any other plan.

Coordination of Benefits with HRA, etc. If the Employer ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the **Health FSA** and the HRA, the **Health FSA** must pay first.

Schedule C
Dependent Care Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

C.1 Benefits

An Employee can elect to participate in the **DCFSA** to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

C.2 Benefit Contributions

The annual Contribution for a Participant's **DCFSA** Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below.

C.3 Eligible Dependent Care Expenses

Under the **DCFSA**, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

- **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be:

    - Employment-related expenses under Code §21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and

    - Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.

    If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the **DCFSA** can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

- **Qualifying Individual.** A Qualifying Individual is:

    - A tax dependent of the Participant, as defined in Code §152, who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

    - A tax dependent of the Participant, as defined in Code §152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- A Participant's Spouse, as defined in Code §152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code §152(e).

- **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means services that both:
  - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the **DCFSA** and during the Period of Coverage; and
  - Are performed:
    - In the Participant's home; or
    - Outside the Participant's home for:
      - The care of a Participant's Dependent who is under age 13; or
      - The care of any other Qualifying Individual who regularly spends at least 8 hours per day in the Participant's household.

        In addition, if the expenses are incurred for services provided by a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services, then the facility must comply with all applicable state and local laws and regulations.
- **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:
  - An individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or Participant's Spouse;
  - A Participant's Spouse;
  - A Participant's child, as defined in Code §152(f)(I), who is under 19 years of age at the end of the year in which the expenses were incurred; and
  - A Participant's Spouse's child, as defined in Code §152(a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

C.4 Maximum And Minimum Benefits

- **Maximum Reimbursement Available and Statutory Limits.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts

credited to the Participant's **DCFSA,** less amounts debited to the Participant's **DCFSA** pursuant to the Maximum Contribution paragraph below.

Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Section have been satisfied.

No reimbursement otherwise due to a Participant under this Plan shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year to date amount of Participant Contributions to the **DCFSA** for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limits.** The maximum dollar limit for a Participant is the smallest of the following amounts:
  - The Participant's Earned Income for the calendar year;
  - The Earned Income for the calendar year of the Participant's Spouse who:
    - Is not employed during a month in which the Participant incurs a Dependent Care Expense; and
    - Is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of $250 per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of $500 per month); or
  - $5,000 for the calendar year, if:
    - The Participant is single or is the head of the household for federal income tax purposes;
    - The Participant is married and files a joint federal income tax return; or
    - The Participant is married, files a separate federal income tax return, and meets the following conditions:
      - The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
      - The Participant furnishes over half of the cost of maintaining such household during the taxable year; and
      - During the last six months of the taxable year, the Participant's Spouse is not a member of such household.
  - $2,500 for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

- **Minimum Dollar Limits.** The minimum annual Benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $300.00.

- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.

- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual benefit amount stated above. The maximum annual benefit amount will not be prorated.

- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the **DCFSA** component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

    - The aggregate Contribution for the period prior to such election change; to

    - The total Contribution for the remainder of such Period of Coverage to the **DCFSA**; reduced by

    - All reimbursements made during the entire Period of Coverage.

C.5 Establishment of Account

The Plan Administrator will establish and maintain a **DCFSA** with respect to each Participant who has elected to participate in the **DCFSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account established under the **DCFSA** will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's **DCFSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- **Debiting of Accounts.** A Participant's **DCFSA** will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

- **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's **DCFSA**, less any prior reimbursements. A Participant's **DCFSA** may not have a negative balance during a Period of Coverage.

C.6 Unused Year End Balance

- **Use It or Lose It Rule**. If any balance remains in the Participant's **DCFSA** after all reimbursements have been made for the Period of Coverage, it shall not be carried over to reimburse the

Participant for Dependent Care Expenses incurred during the subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

- **Use of Forfeiture**. All forfeitures shall be used by the Plan in the following ways:
    - First, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;
    - Second, to reduce the cost of administering the **DCFSA** during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
    - Third, to provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with prevailing IRS guidance.

C.7 Unclaimed Benefit Payments

Any benefit payments that are processed, but not cashed within thirteen months of such benefit payment's issue date shall be turned over to the applicable state's unclaimed property fund pursuant to Section 8.8.

C.8 Reimbursement Procedure

- **Timing.** Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to receive **DCFSA** Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting a claim to Surency within 75 days of the Period of Coverage, setting forth:
    - The person or persons on whose behalf Dependent Care Expenses have been incurred;
    - The nature and date of the expenses incurred;
    - The amount of the requested reimbursement;
    - The name of the person, organization or entity to whom the expense was or is to be paid;
    - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;

- The Participant's certification that they have no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and

- Other such details about the expenses that may be requested by the Plan Administrator.

The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claims for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $25.

- **Claims Denied.** For appeals of claims that are denied, see the Appeals Procedure in the Plan Document.

C.9 Reimbursements After Termination

When a Participant ceases to be a Participant under Section 4.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant or the Participant's estate, may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim within 75 days after the date that the Participant ceases to be a Participant.

C.10 DCFSA Participant vs. Claiming the Dependent Care Tax Credit

Employees often have the choice between participating in their employer's **DCFSA** on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code §21. Employees may not take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.