

COMMUNITY CONSOLIDATED SCHOOL DISTRICT #181

FLEXIBLE BENEFITS PLAN

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Please note: Depending upon your election of benefits, certain benefits in this Summary Plan Description may or may not pertain to you. Please contact your Human Resources Department for questions concerning election of benefits.

This booklet describes the Flexible Benefits for Eligible Employees of Community Consolidated School District #181 and its divisions, affiliates and subsidiaries covered under these provisions.

Information Applicable to Plan 503

Employer Identification Number
36-6004536

**The Benefits In This Booklet Are
Amended and Restated Effective
1/1/2024**

Original Effective Date
7/1/2006

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January 1, 2024

To All Eligible Employees of Community Consolidated School District #181:

This document describes the Community Consolidated School District #181 Flexible Benefits Plan. It is a summary of the official Plan documents that govern the operation of the Plan. If you have any questions about the material in this document or if you would like to review the official Plan document, please contact the Human Resources Department.

This summary is meant to be consistent with the Plan document. Also, this document is intended to comply with Section 125 and Section 129 of the Internal Revenue Code.

This document is also intended to comply with the Patient Protection and Affordable Care Act ("ACA"). As such, Employees are allowed to make pre-tax salary reduction contributions for health benefits (including a health flexible spending account) for children who have not attained age 27 as of the end of the taxable year, who pursuant to ACA, are properly enrolled in coverage for such benefits.

The above provisions do not, and are not intended in any way to, expand the definition of "child" contained in any applicable medical, dental and/or vision plans.

DEFINITIONS

Certain terms used in this summary will be capitalized and are described as follows:

Child. The son, daughter, stepson, or stepdaughter of the Employee, and a Child includes both a legally adopted individual of the Employee and an individual who is lawfully placed with the Employee for legal adoption by the Employee. A Child also includes an "eligible foster child," defined as an individual who is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Employee. A person who customarily works with the Employer of at least seventeen and one-half (17.5) hours per week.

Employer. Community Consolidated School District #181 and any affiliated Employer that adopts the Plan according to the legal documents under which the Plan is established.

Flexible Benefits Plan Enrollment Form. The agreement, which permits the Employer to reduce the participant's current salary and contribute the amount of the reduction to purchase benefits on behalf of the participant.

Grace Period. The two and one-half (2^{1/2}) month period of time from the last day of the Plan Year in which a participant can apply any unused amounts in his or her dependent care assistance (DCA) expenses from the previous Plan Year to pay for covered expenses incurred during the two and one-half (2^{1/2}) month grace period.

Plan. The Plan is commonly known as the "Community Consolidated School District #181 Flexible Benefits Plan."

Plan Administrator. The person or entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to perform

certain Plan connected services. The Plan Administrator is the Employer.

Plan Fiduciary. The person or entity who has the authority to control and manage the operation and administration of the Plan. The Plan Fiduciary is the Employer.

Plan Sponsor. Community Consolidated School District #181 and any affiliated Employer that adopts the Plan according to the legal documents under which the Plan is established.

Plan Supervisor. The entity providing consulting services to the Employer in connection with the operation of the Plan and performing other functions, including processing of claims. The Plan Supervisor is Allied Benefit Systems, LLC, P.O. Box 211651, Eagan, MN 55121.

Plan Year. The Plan is administered according to its designated benefit plan year and/or each Calendar year basis beginning each January 1 and ending each December 31.

ELIGIBILITY AND ENROLLMENT

The Plan consists of five parts: qualified insurance premiums, Health Savings Account (HSA) contributions, Health Flexible Spending Account (FSA) expenses, Limited Purpose Flexible Spending Account (LPFSA) expenses and Dependent Care Assistance (DCA) expenses.

You are eligible to participate in the Plan if you are an Employee of the Employer working at least seventeen and one-half (17.5) hours per week and have been employed for at least ninety (90) days. You become a participant on the first pay period after you meet the eligibility requirements and you enroll.

INITIAL ENROLLMENT

Enrollment in the qualified insurance premiums portion of the Plan is automatic upon completion of the applicable enrollment form(s) provided by the Employer. If you do not complete the applicable enrollment form(s), you will not be able to participate in the qualified insurance premiums portion of the plan until a designated subsequent benefit open enrollment period or you experience a Change in Status event.

To enroll in a Health Savings Account (HSA) you must be covered by a HSA-qualified high deductible health plan (HDHP). To contribute to a HSA, you must complete the applicable enrollment form provided by the Company and you cannot be covered by another health plan, including Medicare, and you cannot be claimed as a dependent on another individual's tax return.

To enroll in the FSA, LPFSA and DCA portions of the Plan, you must complete a Flexible Benefits Plan Enrollment Form. If you do not complete a Flexible Benefits Plan Enrollment Form, you will not be able to participate in these portions of the Plan until a subsequent open enrollment period or you experience a Change in Status event.

SUBSEQUENT ANNUAL OPEN ENROLLMENT

If you do not complete the applicable enrollment form(s) during a designated subsequent benefit open enrollment period, your participation in the qualified insurance premiums and/or health savings account (HSA) portion of the Plan will automatically renew on its designated subsequent benefit plan year at the new amounts. You will be considered to have agreed to pay the appropriate premium for the designated subsequent benefit plan year for the coverage based on your current election. However, you must complete a new Flexible Benefits Plan

Enrollment Form each year for the FSA, LPFSA and DCA portions of the Plan in order to participate in subsequent Plan Years. If you fail to submit a completed Flexible Benefits Plan Enrollment Form during a designated open enrollment period to elect to participate in these portions of the Plan, you will not be able to participate in the Plan for that Plan Year (unless you experience a Change in Status event).

TERMINATION OF COVERAGE

You remain a participant in the Plan until you no longer meet the eligibility requirements. In regards to the FSA and LPFSA portions of the Plan, expenses incurred prior to the termination date are reimbursable, and may be submitted for reimbursement up to 90 days after the end of the Plan Year. Expenses incurred after the termination date, are only reimbursable if you elect continuation coverage (COBRA). If you are eligible for and elect COBRA, you may continue contributing to the FSA and LPFSA portion of the Plan on an after-tax basis only.

Also, if you separate from service or otherwise cease to be eligible under the DCA expenses portion of the Plan, you may continue to submit for reimbursement eligible claims incurred during the Plan Year. DCA expenses incurred after the Plan Year ends are not reimbursable. Except as indicated above, no additional contributions to the Plan are allowed.

“Continuation Coverage” under COBRA means your right, to continue the coverage under the FSA and LPFSA portion of the Plan that was in place the day before a Qualifying Event if participation by you otherwise would end due to the occurrence of such Qualifying Event.

A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your Spouse;
- your becoming entitled to receive Medicare benefits; or
- your dependent’s ceasing to be a dependent.

Participants under the FSA and LPFSA portion of the Plan will be eligible for COBRA continuation coverage if they have a positive account balance at the time of a Qualifying Event (taking into account all claims submitted before the date of the qualifying event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the FSA and LPFSA expenses portion of the Plan will cease at the end of the year and cannot be continued for the next Plan Year. If you are eligible to elect COBRA with respect to the FSA and LPFSA accounts, you may continue participation by making after-tax contributions to the Plan on a monthly basis in an amount equal to 102% of the pay reductions that were allocated prior to your termination. After-tax contributions for a month are due on the first day of each month. However, there is a 30 day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

REVOCACTION OF ELECTION

Generally, once you make a decision with respect to benefits, you may not revoke that

election during the Plan Year or the designated benefit plan year. However, you may change your election during the Plan Year or during a designated benefit plan year if you experience a change in status or event changes. You must notify Human Resources within 30 days of these events in order to make a change. If you do not notify Human Resources within 30 days of the event, you must wait until the next annual open enrollment period to make an election change. The next section describes these situations in which it may be permissible to make a change:

A. Changes in Status

1. Change in status events

You may revoke an election during the Plan Year or the designated benefit plan year and make a new election for the remaining period of coverage under the Plan if there is a change in status as described below and if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. The Plan Administrator shall determine whether a requested change is on account of and corresponds with a change in status.

- (a) Legal marital status. Events that change an Employee's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.
- (b) Number of dependents. Events that change an Employee's number of dependents, including the following: birth; death; adoption; and placement for adoption, as well as a Child becoming newly eligible for coverage or eligible for coverage beyond the date on which the Child otherwise would have lost coverage.
- (c) Employment status. Events that change the employment status of an Employee, an Employee's spouse, or an Employee's dependent, including the following: 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, and the switching from part-time to full-time employment status or from full-time to part-time status by an Employee or an Employee's spouse or dependent.
- (d) Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause an Employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.
- (e) Residence. A change in the place of residence of an Employee, spouse or dependent. Note: The change in residence must result in the Employee, Employee's spouse or dependent gaining or losing eligibility under a plan.

If the change in status is (a) an Employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent or (b) a dependent ceasing to satisfy the eligibility requirements for coverage, then an Employee may only elect to cancel coverage for the affected spouse or dependent. Canceling coverage for any other individual under these circumstances would fail to correspond with that change in status and therefore is not a permitted election change.

If an Employee, spouse or dependent gains eligibility for coverage under a plan sponsored by the employer of the Employee's spouse or dependent as a result of a change in Legal marital status or change in Employment Status, an Employee may change an election to cease or decrease coverage for that individual under the Plan only if coverage for that individual becomes applicable (i.e. effective) or is increased under the other employer's plan.

Applicability to DCA expenses portion of the Plan: An election change relating to the DCA expenses portion of the Plan is permitted only if (a) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan or (b) the election change is on account of and corresponds with a change in status that affects DCA expenses available under Section 129 of the Internal Revenue Code. (For example: A DCA expenses election may be canceled where a dependent child turns age 13 in the middle of the Plan Year).

Applicability to the FSA and LPFSA portions of the Plan: Election changes related to the FSA and LPFSA portions of the Plan are not permitted under this section B (Cost or Coverage Changes).

B. Cost or Coverage Changes

1. Automatic increase or decrease for cost changes.

If the cost of a qualified benefits plan increases or decreases during a period of coverage, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Employees' elective contributions to reflect such cost changes.

2. Significant cost increases.

If the cost of a benefit package option (such as a PPO option or HMO option under a health plan) significantly increases during a period of coverage as determined by the Plan Administrator, you may elect to make a corresponding prospective increase in your payments, or to revoke your election and, in lieu thereof, to receive on a prospective basis coverage under another benefit package option providing similar coverage.

Applicability to the DCA expenses portion of the Plan: An Employee participating in the DCA expenses portion of the Plan may change an election based upon a significant increase in cost of the dependent care provider only if the cost change is imposed by a dependent care provider who is not a relative of the Employee (For example, the Employee's parent(s), child(ren), brother(s), sister(s), etc.)

3. Coverage changes.

If the coverage under a plan is significantly curtailed or ceases during a period of coverage, you may revoke your election and make a new election on a prospective basis for coverage under another benefit package option providing similar coverage. Coverage is considered significantly curtailed only if there is an overall reduction in coverage provided to participants under a plan so as to constitute reduced coverage to participants generally.

If a plan adds a new benefit package option or other coverage option (or eliminates an existing benefits package option or other coverage option), you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively on a pre-tax basis and make a corresponding election change with respect to other benefit package options providing similar coverage.

Applicability to DCA expenses portion of the Plan: The availability of dependent care services from a new child care provider during the Plan Year does constitute a significant change in coverage similar to a benefit package option becoming available. Accordingly, you are permitted to revoke your previous election under the DCA expenses portion of the Plan and make a corresponding new election to reflect the cost of the new child care provider. In addition, a change in the number of hours of work performed by a child care provider constitutes a change in coverage enabling you to make a corresponding new election to reflect the new cost of the child care provider.

Applicability to the FSA portion of the Plan: Election changes related to the FSA portion of the Plan are not permitted under this section B (Cost or Coverage Changes).

C. Other Permitted Mid-year Election Changes

1. Special Enrollment Rights under HIPAA

You may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. Judgment, Decree or Order.

The Plan may change your election to provide coverage for your child if a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for the child. If a judgment, decree or order requires your spouse, former spouse, or other individual to cover the child, you may change his/her election to revoke coverage for the child.

3. Entitlement to Medicare or Medicaid

You may change an election on a prospective basis to cancel or reduce coverage for yourself or your spouse or dependent under a plan if you, your spouse or dependent who is enrolled in a plan subsequently becomes enrolled under Part A or Part B of Medicare or entitled to Medicaid. Conversely, you may change an election on a prospective basis to commence or increase coverage for yourself or your spouse or dependent if you or your spouse or dependent who had been entitled to Medicare or Medicaid subsequently loses eligibility for coverage under Medicare or Medicaid.

4. The Family and Medical Leave Act

If you take leave under the Family and Medical Leave Act (FMLA), you may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

5. Change in Coverage of Spouse or Dependent under other Employer's plan

You may change an election on a prospective basis that is on account of and corresponds with a change made under the plan of a spouse's or dependent's employer if (a) the plan of the spouse's or dependent's employer permits participants to make election changes that would be permitted under IRS regulations under Section 125 of the Code or (b) the Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the plan of the spouse's or dependent's employer.

6. Changes Allowed Under Current Regulations

You may change an election on a prospective basis that is on account of and corresponds with any other permitted change under the current IRS regulations under Section 125 of the Code.

7. Reduction of Hours

You may prospectively revoke an election for coverage (that is not a health FSA, but provides minimum essential coverage) if you experience a change in employment status, such that 1) you are no longer expected to work an average of at least 30 hours of service per week, but 2) the reduction in hours does not result in you ceasing to be eligible for coverage. The revocation of the election of coverage must correspond to your intent to enroll yourself and any eligible dependents (who cease coverage due to the revocation) in another plan that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

8. Enrollment in a Qualified Health Plan through the Marketplace

You may prospectively revoke an election for coverage (that is not a health FSA, but provides minimum essential coverage) if you are eligible for a special or annual enrollment period to enroll in a Qualified Health Plan through the Health Insurance Marketplace ("Marketplace") established under section 1311 of the Affordable Care Act. The revocation of the election of coverage must correspond to your intent to enroll yourself and any eligible dependents (who cease coverage due to the revocation) in the Qualified Health Plan, the effective date for which is no later than the day immediately following the last day of coverage through your group health plan.

You may prospectively revoke an election for family coverage (that is not a health FSA, but provides minimum essential coverage) if one or more already-covered related individuals are eligible for a special enrollment period to enroll in a Qualified Health Plan through the Marketplace, or one or more already-covered related individuals seek to enroll in a Qualified Health Plan during the Marketplace's annual open enrollment period. The revocation of coverage must correspond to the intended enrollment of the related individual(s) in the Qualified Health Plan for new coverage, the effective date for which is no later than the day immediately following the last day of the revoked coverage.

If you revoke your election during the Plan Year or during a designated benefit plan year for any reason other than those specifically allowed by the Internal Revenue Code and the regulations thereunder, the amount of your contribution during that designated benefit plan year may be included in your gross income.

HOW THE PLAN WORKS

ELECTION OF BENEFITS

Prior to the beginning of each Plan Year or designated subsequent benefit plan year, you will designate your insurance coverage. As noted, if you do not complete the applicable enrollment form(s) during a designated benefit open enrollment period for the qualified insurance premiums and/or health savings account (HSA) contributions portion of the Plan, your participation will automatically renew for the subsequent designated benefit plan year at the new amounts. The available choices are qualified insurance premiums, health savings account (HSA) contributions, limited purpose flexible spending account (LPFSA) expenses, health flexible spending account (FSA) expenses and dependent care assistance (DCA) expenses.

If you elect to participate in the Plan, then you pay for your coverage on a pre-tax basis. Paying for benefits with money which has not yet been taxed may, therefore, increase your take home pay. The result is additional spendable income. You must notify your Human Resources Department in writing within thirty (30) days from becoming eligible in the Plan or within (30) days from the beginning of a new Plan Year or designated benefit plan year, if you wish to not pay for your benefits on a pre-tax basis. The amount you use to pay for such benefits will, therefore, be taxable to you.

You must make your election prior to the beginning of the Plan Year or designated benefit plan year. However, if you become eligible to participate in the Plan after a designated subsequent open enrollment, you may enroll on the date you become eligible. The amount you may pledge will be pro-rated based upon your eligibility date for the FSA expenses, LPFSA expenses or DCA expenses portions of the Plan only.

Each year you will be informed of the premium rates that apply and the total amount you may pledge. The available amount announced each year will be the same for all Employees. The type and amount of coverage you elect will determine your total contribution which the Employer will deduct from your paycheck based on your elections.

The maximum contribution levels are as follows:

- qualified insurance premiums: specified by the Company.
- health savings account (HSA) maximum contributions are follows for **2024**:
 - \$4,150* (self-only coverage under a qualified High Deductible Health Plan)
 - \$8,300* (family coverage under a qualified High Deductible Health Plan)

* If you are age 55 or older, you can contribute \$1,000 in addition to the **2024** HSA maximum amount.

Note: Subsequent years- HSA maximum contribution amounts are indexed annually. Please consult with your Human Resources Department.

- health flexible spending account (FSA) expenses: \$3,200 maximum
- limited purpose flexible spending account (LPFSA) expenses: \$3,200 maximum
- dependent care assistance (DCA) expenses: \$5,000 maximum (\$2,500 maximum for married couples filing separate tax returns.)

CHOICE OF BENEFITS

You may make an election under the terms of the Plan with respect to the following benefits:

(a) Qualified Insurance Premiums

You may allow the Employer to reduce your current salary pursuant to the applicable enrollment form(s) provided by the Employer and make premium payments for coverage under the Employer's qualified insurance plans. Premium payments shall be made directly by the Employer, and benefits shall be paid pursuant to the terms of the applicable benefit plans. The benefit descriptions and all other provisions in such plans and any applicable contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

Such qualified insurance premiums apply to you, your spouse or your dependents (as defined in Section 152 of the Code), as well as your Children who have not attained age 27 as of the end of the taxable year.

(b) Health savings account (HSA) contributions

You must be covered by a HSA-qualified high deductible health plan (HDHP) and you may allow the Company to reduce your current salary pursuant to the applicable enrollment form provided by the Company for contributions to your Health savings account (HSA). You cannot be covered by another health plan, including Medicare, and you cannot be claimed as a dependent on another individual's tax return.

- Medicare Enrollment: All HSA contributions must cease for the current Plan Year maximum contribution amount once a participant is enrolled in any type of Medicare.
- Full Plan Year's Contribution:
 - A full Plan Year's contribution may be made to an HSA if you become eligible under a qualified High Deductible Health Plan at anytime during the Plan Year.
 - If you contribute a full Plan Year's contribution but are eligible for only part of the Plan Year, you will be subject to taxes and penalties if you don't remain a participant in the Plan for 12 months after the Plan Year in which you first become eligible.
- Excess contributions:
 - Contributions to the HSA in excess of the contribution limits must be withdrawn by the participant or be subject to an excise tax.
 - A pro-rata portion of earnings must be withdrawn, also
 - Pay income tax on the withdrawn amount, but no 20% penalty

- If the HSA maximum contribution limit was not reached for the Plan Year, any other withdrawal for the Plan Year (that is not for qualified medical expenses) will not be considered “excess HSA contributions” and this withdrawal will be subject to both income tax and the 20% penalty.
- Contributions are pre-tax:
 - All HSA contributions through this Plan are “pre-tax” and are not subject to individual or employment taxes.

(c) Health Flexible Spending Account (FSA) Expenses

You may not enroll in this portion of the Plan if you are enrolled in a Health savings account (HSA).

You may allow the Employer to reduce your current salary pursuant to a Flexible Benefits Plan Enrollment Form and make payments on your behalf for the subsequent reimbursement of certain FSA expenses. Only those health expenses allowed by Section 213 of the Code may be submitted for reimbursement through this portion of the Plan.

Such expenses may be incurred by you, your spouse or your dependents (as defined in Section 152 of the Code), as well as your Children who have not attained age 27 as of the end of the taxable year. The expense will only be reimbursed to the extent that you or other person is not reimbursed for the expense through any other insurance or other source. Any reimbursement to you under this Plan may not otherwise be claimed as a credit or deduction under the Code.

The following health expenses may be submitted for reimbursement under the FSA expenses portion of the Plan:

- (1) Expenses for medical care as allowed by Section 213 of the Code.
- (2) Expenses incurred for medicines and drugs purchased without a prescription to alleviate or treat personal injuries or sickness if substantiated by a receipt showing, at a minimum, 1) the date purchased, 2) the amount of the purchase, and 3) the specific item(s) purchased.
- (3) Any other expense allowed by the IRS as reimbursable under a flexible spending account.

There are certain expenses that do not qualify. For example, you cannot obtain reimbursement for health club dues, non-prescription eyeglasses or sunglasses, programs or prescriptions to control weight (unless a medical necessity exists) and cosmetic procedures (including teeth bleaching, electrolysis, hair transplants and prescriptions or OTC drugs taken for cosmetic reasons) unless necessary because of injuries you receive or related to a congenital disfigurement.

(d) Limited purpose Flexible Spending Account (LPFSA) Expenses

This option is available only to those participants enrolled in a Health savings account (“HSA”).

You may allow the Company to reduce your current salary pursuant to a Flexible

Benefits Plan Enrollment Form to make payments on your behalf for the subsequent reimbursement of certain medical expenses. Only vision, dental and preventive care expenses as specified by Sections 213 and 223 of the Code may be submitted for reimbursement through this portion of the Plan.

Such expenses may be incurred by you, your spouse or your dependent. The expense will only be reimbursed to the extent that you or other person is not reimbursed for the expense through any other insurance or other source. Any reimbursement to you under this Plan may not otherwise be claimed as a credit or deduction under the Code.

The following medical expenses may be submitted for reimbursement under the LPFSA expenses portion of the Plan:

- (1) Expenses for vision care as allowed by Sections 213 and 223.
- (2) Expenses for dental care as allowed by Sections 213 and 223.
- (3) Expenses for preventive care.

Expenses for preventive care do not generally include any service or benefit intended to treat an existing illness, injury or condition. Preventive care includes, but is not limited to, the following:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs.
- Screening services, including:
 - Cancer Screening
 - Heart and Vascular Diseases Screening
 - Infectious Diseases Screening
 - Mental Health Conditions and Substance Abuse Screening
 - Metabolic, Nutritional, and Endocrine Conditions Screening
 - Musculoskeletal Disorders Screening
 - Obstetric and Gynecologic Conditions Screening
 - Pediatric Conditions Screening
 - Vision and Hearing Disorders Screening

(e) Dependent Care Assistance (DCA) Expenses

A Participant may allow the Employer to reduce his or her current salary pursuant to a

Flexible Benefits Plan Enrollment Form and make payments on behalf of the Participant for the subsequent reimbursement of certain DCA expenses in accordance with Section 129 of the Code.

A Participant may request reimbursement for those dependent care expenses incurred in connection with the following qualifying individuals:

- i. A dependent of the Participant who is under age 13 and with respect to whom the Participant is entitled to a deduction under Section 151(c) of the Code.
- ii. A dependent of the Participant who is physically or mentally incapable of caring for himself or herself.
- iii. The spouse of the Participant, if he or she is physically or mentally incapable of caring for himself or herself.
- iv. Any other individual defined under Section 21(b) of the Code.

Expenses will only be reimbursed to the extent they allow the Participant and spouse, if any, to be gainfully employed. Such expenses include costs for the care of a qualifying individual described above and related household services.

Also, a Participant may request reimbursement for those expenses incurred outside the Participant's home for the care of a qualifying individual described in (1) above or for the care of those qualifying individuals described in (2) and (3) above if those individuals regularly spend at least eight (8) hours each day in the Participant's household.

Expenses incurred outside the Participant's home at a dependent care center are reimbursable only if such center complies with all applicable laws and regulations of the appropriate State or unit of local government or any other requirement under the Code.

Expenses paid to the spouse or other dependent of the Participant for the care of any qualifying individual are not reimbursable. Any reimbursement under this Plan may not otherwise be claimed as a credit or deduction under the Code. Notwithstanding the above, only expenses specifically allowed by Sections 21, 129 or any other related section of the Code will be reimbursed.

FICA

It is important to note that because you are enjoying the benefits of pre-tax savings, you will be paying less FICA for your future Social Security retirement. Your eventual benefit under Social Security will, therefore, be slightly reduced. Most Employees see only a very slight reduction in benefits.

UNIFORM COVERAGE

Under the FSA and LPFSA portion of the Plan only, the total amount of your elective annual contribution will be available for reimbursement to you at any time during the Plan Year.

LOSS OF BENEFITS

If you do not use all of the amounts which you contribute to the FSA and LPFSA portions of the Plan during the Plan Year, you will nonetheless be able to carryover up to \$640 of these unused amounts remaining at the end of the Plan Year (or at the end of the run-out period) for applicable FSA expenses incurred in the subsequent Plan Year. (As such, any unused amount in

excess of \$640 that remains unused as of the end of the Plan Year (or at the end of the run-out period) is forfeited, and such amount will be returned to the Company.) However, if you do not use all of the amounts which you contribute to the DCA portion of the Plan during the Plan Year or Grace Period, you will lose these amounts in their entirety, and they will be returned to the Company. You cannot commingle your salary reduction amounts among the various portions of the Plan. Therefore, you should be conservative in estimating your expenses.

The Heroes Earnings Assistance and Relief Tax Act of 2008 (“HEART Act”), allows military reservists called to active duty for a period of at least 180 days (or for an indefinite period of time) who participate in the Plan to obtain distributions of their unused balances from their FSA or LPFSA. These distributions will be made during the period beginning on the date of the call to active duty, and end on the last date reimbursements could be made under the FSA or LPFSA for that Plan Year. You must notify your Human Resources Department by the last date reimbursements end for that Plan Year to receive this distribution. The distribution will be taxable to you.

CLAIMS PROCEDURE

Claims for benefits under any qualified insurance plan should be submitted in accordance with the procedures established by the applicable plans.

You may receive distributions from your Health Savings Account (HSA) at any time. You may withdraw your funds by either using your debit card provided by the HSA custodian or trustee or by issuing a check from your HSA account. It is important to remember that you control the distributions from your HSA. You will be required to report distributions on your income tax returns. Therefore, please keep all your receipts for any qualified medical expenses. Also, distributions from your HSA for qualified medical expenses are tax free. If, however, you take a distribution for a non-qualified expense, you will be required to pay the appropriate tax and any applicable penalty.

Reimbursement claims for the FSA expenses or LPFSA expenses (non-Allied Flex Debit Card) and DCA expenses must be submitted in writing on the form provided. DCA expenses may only be reimbursed if you provide a written statement stating that the expense has been incurred during the Plan Year or Grace Period, the amount of such expense and that the expense has not been reimbursed or is not reimbursable under any other plan. FSA or LPFSA expenses may only be reimbursed if you provide a written statement stating that the expense has been incurred during the Plan Year, the amount of such expense and that the expense has not been reimbursed or is not reimbursable under any other plan. Use of the Allied Flex Debit Card is only available for use for the FSA or LPFSA expenses (non-Allied Flex Debit Card) and DCA expenses must be submitted in writing on the form provided. Please note that you are still required to keep all receipts since you may be asked for the receipts in order to substantiate the claim. All such claims must be submitted within 90 days following the end of the Plan Year. Your failure to do so will result in the denial of the charges.

After a FSA, LPFSA or DCA claim is processed, an electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an “Adverse Benefit Determination” and is subject to the provisions detailed below.

The Plan will notify you of an Adverse Benefit Determination within 30 days after receipt of

the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan determines that the extension is necessary due to matters beyond the control of the Plan and you are notified prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days within which to provide the specified information.

A notice of Adverse Benefit Determination will include the following:

- ◆ The specific reason or reasons for the adverse determination.
- ◆ Reference to specific plan provisions on which the adverse determination is based.
- ◆ A description of the Plan's appeal procedures and the time limits applicable to such procedures.
- ◆ If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.
- ◆ If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

APPEALS

If you receive an Adverse Benefit Determination, you or your authorized representative may appeal the determination by filing a written application with the Plan. In appealing an Adverse Benefit Determination, the Plan will provide you or your authorized representative:

- ◆ The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- ◆ Upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- ◆ A full and fair review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- ◆ A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

- ◆ In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- ◆ Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

An appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan will notify you or your authorized representative of the Plan's determination within 60 days after receipt of an appeal.

The Plan's determination

- will be in writing setting forth specific reasons for the decision and reference to the specific plan provisions upon which the determination is based.
- will contain a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.
- if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

ADMINISTRATION OF THE PLAN

Calendar records are maintained for a Plan Year ending the last day of December each year or a designated benefit plan year. The Plan is a legal entity. Legal notices may be filed with and legal process served upon the Plan Administrator.

As Plan Administrator and Plan Fiduciary, the Employer has complete authority to control and manage the operation and administration of the Plan. In exercising its fiduciary and other responsibilities, the Employer shall have the discretionary authority to determine eligibility for benefits, review any denied claims for benefits and construe disputed Plan terms. The Employer shall be deemed to have properly exercised such authority, unless it has abused its discretion

by acting arbitrarily and capriciously.

The Employer reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. The authority to make any such changes to the Plan rests with an authorized representative of the Employer. Any such amendment, modification, revocation or termination of the Plan shall be made by a written amendment signed by an authorized representative. The Plan Administrator shall communicate such changes to Plan participants. Plan participants will be furnished with summary descriptions of material modifications not later than 210 days after the end of the Plan Year in which the change is adopted. Any modification or change that is a material reduction in benefits provided under the Plan will be communicated to participants not later than 60 days after adopting the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

If you have any questions regarding your FSA, LPFSA, or DCA claim submission or claim status, please contact:



Allied Benefit Systems, LLC

P.O. Box 211651

Eagan, MN 55121

P 312-906-8080

F 312-906-8359

E FlexClaims@Alliedbenefit.com

**STANDARDS FOR PRIVACY AND SECURITY OF INDIVIDUALLY
IDENTIFIABLE HEALTH INFORMATION ISSUED PURSUANT TO THE
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF
1996, AS AMENDED (“HIPAA”)**

A. Privacy Standards.

1. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI 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 PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

The Human Resources Manager, Staff designated by Human Resources Manager, Chief Financial Officer and Staff designated by Chief Financial Officer.

- ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” functions are activities that would meet the definitions of treatment, payment and health care operations. “Plan Administration” functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management and eligibility information requests. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

2. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

3. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

B. Security Standards.

1. Definitions.

- a. The term “Electronic Protected Health Information” (“E PHI”) has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.
- b. The term “Security Incidents” has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of

information or interference with systems operations in an information system.

2. Plan Sponsor Obligations.

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and
 - ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.
- e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (“Notice”) describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan’s legal obligations concerning a Covered Person’s protected health information and describes a Covered Person’s rights to access, amend and manage that protected health information.

Protected health information (“PHI”) is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person’s past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the Human Resources Department.

THE PLAN’S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Person’s PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan’s legal duties and of its privacy practices with respect to the Covered Person’s PHI, abide by the terms of the Notice that is currently in effect, and notify the Covered Person in the event of a breach of the Covered Person’s unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;

- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

TREATMENT

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

PAYMENT

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

HEALTH CARE OPERATIONS

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

REQUIRED BY LAW

The Plan may use or disclose PHI to the extent the law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person’s PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such

disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

LAW ENFORCEMENT

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

RESEARCH

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

INMATES

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety

and the health and safety of others or (3) the safety and security of the correctional institution.

WORKERS' COMPENSATION

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

FUNDRAISING ACTIVITIES

The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

GROUP HEALTH PLAN DISCLOSURES

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

UNDERWRITING PURPOSES

The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

OTHERS INVOLVED IN YOUR HEALTH CARE

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

OTHER COVERED ENTITIES

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with

payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON’S AUTHORIZATION

SALE OF PHI

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person’s PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

MARKETING

The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person’s PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

PSYCHOTHERAPY NOTES

The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person’s psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person’s written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A COVERED PERSON’S RIGHTS

The following is a description of a Covered Person’s rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the Human Resources Department. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the Human Resources Department. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial

claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits “EOB”). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person’s PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the Human Resources Department as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person’s PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

RIGHT TO INSPECT AND COPY

A Covered Person has the right to inspect and copy PHI that is contained in a “designated record set.” Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person’s health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the Human Resources Department. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person’s request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the Human Resources Department. A licensed health care professional chosen by the Plan will review the Covered Person’s request and the denial. The person performing this review will not be the same one who denied the Covered Person’s initial request. Under certain conditions, the Plan’s denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

RIGHT TO AMEND

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the Human Resources. Additionally, this request

should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

RIGHT OF AN ACCOUNTING

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the Human Resources Department. It is important that the Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

RIGHT TO A COPY OF THIS NOTICE

The Covered Person has the right to request a copy of this Notice at any time by contacting the Human Resources Department. If you receive this Notice on the Plan's website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the Human Resources Department. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health

and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

COMMUNITY CONSOLIDATED SCHOOL DISTRICT #181

FLEXIBLE BENEFITS PLAN

PLAN DOCUMENT

Amended and Restated Effective 1/1/2024.

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ARTICLE I
ESTABLISHMENT OF THE PLAN

1. Establishment of Plan.

Community Consolidated School District #181 (the “Employer”) hereby establishes a cafeteria plan within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, for its eligible Employees effective 1/1/2024, to be known as the “Community Consolidated School District #181 Flexible Benefits Plan (the “Plan”). The Plan was originally effective as of 7/1/2006. The Plan is amended and restated effective as of 1/1/2024.

The purpose of this Plan is to provide eligible Employees a method of obtaining a reimbursement of health coverage and other permissible benefits. Such benefits are provided in a manner which allows the Employee the discretion to choose those benefits which are best suited to the Employee’s needs and obtain them with advantageous tax treatment.

2. Applicability of Plan.

The provisions of this Plan are applicable only to the Employees of the Employer in current employment on or after the Effective Date.

An Employee who retired or separated from employment prior to the Effective Date shall not be entitled to benefits after the Effective Date under the provisions of this Plan unless the Employee is rehired and then becomes eligible for benefits.

The provisions of this Plan for the reimbursement of health coverages are intended to qualify as a medical reimbursement plan within the meaning of Code Section 105(b). The provisions of this Plan for the reimbursement of dependent care assistance (DCA) expenses are intended to qualify as a DCA plan within the meaning of Code Section 129.

The provisions of this Plan are also intended to comply with the Patient Protection and Affordable Care Act (“ACA”). As such, Participants are allowed to make pre-tax salary reduction contributions for health benefits (including a health flexible spending account) for children who have not attained age 27 as of the end of the taxable year, who pursuant to ACA, are properly enrolled in coverage for such benefits.

The above provisions do not, and are not intended in any way to, expand the definition of “child” contained in any applicable medical, dental and/or vision plans.

ARTICLE II
DEFINITIONS

1. Definitions.

The following terms shall have the respective meanings set forth below. When the defined meaning is intended, the term is capitalized.

- (a) The term “Child” means the son, daughter, stepson, or stepdaughter of the Participant, and a Child includes both a legally adopted individual of the Participant and an individual who is lawfully placed with the Participant for legal adoption by the Participant. A Child also includes an “eligible foster child,” defined as an individual who

is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

- (b) The term “Code” means the Internal Revenue Code of 1986, as amended.
- (c) The term “Effective Date” means 7/1/2006. The Plan is amended and restated effective as of 1/1/2024.
- (d) The term “Employee” means a common-law employee of the Employer.
- (e) The term “Employer” means Community Consolidated School District #181 and to the extent described in a supplemental agreement to this Plan, an affiliated organization which adopts this Plan pursuant to Article XII of this Plan.
- (f) The term “Flexible Benefits Plan Enrollment Form” means the agreement, which permits the Employer to reduce the Participant’s current salary and contribute the amount of the reduction to purchase benefits on behalf of the Participant.
- (g) The term “Grace Period” means the two and one-half (2^{1/2}) month period of time from the last day of the Plan Year in which a Participant can apply any unused amounts in his or her DCA expenses account from the previous Plan Year to pay for covered expenses incurred during the two and one-half (2^{1/2}) month grace period.
- (h) The term “Highly Compensated Employee” means any Employee who (1) was at any time during the current or preceding Plan Year a 5-percent owner of the Employer; or (2) for the preceding Plan Year, received compensation from the Employer in excess of the amount established by the Internal Revenue Service and was in a group consisting of the top 20 percent of the Employees when ranked on the basis of compensation paid during such year; or (3) any other individual who falls within the provisions of Section 125(e) of the Code or Section 414(q) of the Code (as amended).
- (i) The term “Key Employee” means any Employee who at any time during the Plan year is (1) an officer of the Employer receiving compensation from the Employer in excess of the amount established by the Internal Revenue Service, or (2) a 5-percent owner of the Employer; or (3) a 1-percent owner of the Employer having an annual compensation from the Employer of more than the amount established by the Internal Revenue Service; or (4) any other individual who falls within the provisions of Section 416(i)(1) of the Code (as amended).
- (j) The term “Participant” means an Employee who meets the conditions of Article III.
- (k) The term “Plan” means the “Community Consolidated School District #181 Flexible Benefits Plan” which is intended to qualify as a cafeteria plan within the meaning of Code Section 125. This plan also serves as the written plan document for the Employer’s program of DCA reimbursement which is intended to qualify as a DCA plan within the meaning of Code Section 129.
- (l) The term “Plan Administrator” means the person or entity responsible for the day-to-day functions and management of the Plan. The plan administrator may employ persons or firms to perform certain Plan connected services. The plan administrator is the Employer.
- (m) The term “Plan Fiduciary” means the person or entity who has the authority to control

and manage the operation and administration of the Plan. The Plan Fiduciary is the Employer.

- (n) The term “Plan Sponsor” means Community Consolidated School District #181 and to the extent described in a supplemental agreement to this Plan.
- (o) The term “Plan Supervisor” means the entity providing consulting services to the Employer in connection with the operation of the Plan and performing other functions, including processing of claims. The Plan Supervisor is Allied Benefit Systems, LLC, P.O. Box 211651, Eagan, MN 55121.
- (p) The term “Plan Year” means the Plan is administered according to its designated benefit plan year and/or each Calendar year basis beginning each January 1 and ending each December 31.

2. Gender and Number.

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any term in the singular shall also include the plural.

ARTICLE III ELIGIBILITY AND PARTICIPATION

1. Date of Participation.

A person who is an Employee of the Employer, who is employed for at least seventeen and one-half (17.5) hours per week and have been employed for at least ninety (90) days, shall become a Participant in the Plan on the first pay period after meeting the eligibility requirements and upon completion of the necessary enrollment forms.

Enrollment in the qualified insurance premiums portion of the Plan is automatic upon completion of the applicable enrollment form(s) provided by the Employer. Participants must notify the Employer in writing within thirty (30) days from becoming eligible in the designated subsequent benefit plan if they wish to not pay for benefits on a pre-tax basis.

A person who is an Employee of the Company, who is covered by a HSA-qualified high deductible health plan (HDHP), may enroll in a Health Savings Account (HSA) by completing the applicable enrollment form(s) provided by the Company and cannot be covered by another health plan, including Medicare, and cannot be claimed as a dependent on another individual's tax return. For subsequent plan years, those who participate in the qualified insurance premiums and/or health savings account (HSA) contributions portion of the Plan will automatically renew each year at the new contribution amounts unless the Participant otherwise notifies the Company in writing within thirty (30) days from becoming eligible in the new Plan Year.

A Flexible Benefits Plan Enrollment Form must be completed to enroll in the health flexible spending account (FSA) expenses, limited purpose flexible spending account (LPFSA) expenses and dependent care assistance (DCA) expenses portions of the Plan. If a Flexible Benefits Plan Enrollment Form or the applicable enrollment form(s) are not completed, participation will not begin until a subsequent open enrollment period or a Change in Status event occurs.

2. Duration.

A Participant shall cease to be a Participant when the conditions of section 1 are no longer satisfied.

ARTICLE IV BENEFITS

1. Election.

The Plan offers the Participant a choice between certain taxable and nontaxable benefits. Accordingly, prior to the beginning of each designated benefit plan year, a Participant will choose benefits, pledge an amount to pay for the cost of those benefits and then decide whether the cost of that coverage will be paid on a pre-tax or an after-tax basis. Any pre-tax premium payments shall be made directly by the Company on behalf of the Participant through the applicable enrollment form(s) provided by the Company. The enrollment in the qualified insurance premiums and/or health savings account (HSA) contributions portion of the Plan will be automatically renewed each subsequent benefit plan year unless the Participant otherwise notifies the Company in writing within (30) days from the start of a new benefit plan year if they wish to not pay for benefits on a pre-tax basis.

The maximum contribution levels are as follows:

- qualified insurance premiums: specified by the Company.
 - health savings account (HSA) maximum contributions are follows for **2024**:
 - \$4,150* (self-only coverage under a qualified High Deductible Health Plan)
 - \$8,300* (family coverage under a qualified High Deductible Health Plan)
- * If you are age 55 or older, you can contribute \$1,000 in addition to the **2024** HSA maximum amount.

Note: Subsequent years- HSA maximum contribution amounts are indexed annually. Please consult with your Human Resources Department.

- health flexible spending account (FSA) expenses: \$3,200 maximum
- limited purpose flexible spending account (LPFSA) expenses: \$3,200 maximum
- dependent care assistance (DCA) expenses: \$5,000 maximum (\$2,500 maximum for married couples filing separate tax returns.)

The amount stated above shall be determined at the discretion of the Employer prior to the commencement of each Plan Year or designated subsequent benefit plan year and shall be uniformly applicable to all Participants. That amount shall be subject to review and final approval by the Employer. A Participant's rate of salary shall not include any bonus payments, fringe benefits or other special compensation. The Employer reserves the right to reduce the amount of the Participant's Flexible Benefits Plan Enrollment Form in order to assure compliance with the requirements of the Code for favorable tax treatment.

2. Nondiscrimination.

It shall be the responsibility of the Employer to ensure compliance with any applicable

nondiscrimination requirements. The Plan will not discriminate in favor of Highly Compensated Employees as to benefits or contributions for the Plan Year.

The benefits provided to Key Employees shall not exceed 25% of the aggregate of such benefits provided for all Participant's under the Plan.

Not more than 25% of the amounts paid by the Employer for DCA during the Plan Year may be provided to individuals owning more than 5% of the Employer. In addition, the average benefit provided to non-highly compensated Employees will be at least 55% of the average benefit to Highly Compensated Employees.

Any reduction required of a Participant's salary shall be done on a reasonable and nondiscriminatory basis and will be done on a common dollar value basis rather than a pro-rata basis.

3. New Participants.

If an Employee becomes a Participant in the Plan after the beginning of a Plan Year, the amount pledged will be pro-rated based upon the Participant's eligibility date for the FSA expenses, LPFSA expenses or DCA expenses portions of the Plan only.

4. Terminating Participants.

If a Participant terminates employment prior to the end of a Plan Year or designated benefit plan year, his or her participation in the Plan shall cease. However, in regards to FSA expenses or LPFSA expenses portion of the Plan, expenses incurred prior to termination date are reimbursable, and may be submitted for reimbursement up to 90 days after the end of the Plan Year. However, a Participant who terminates employment and is eligible for continuation coverage (COBRA) may be allowed to continue to contribute to the FSA expenses or LPFSA expenses portion of the Plan on an after-tax basis only. Also, those Participants who separate from service or otherwise cease to be eligible under the DCA expenses portion of the Plan, may continue to submit for reimbursement eligible claims incurred during the Plan Year. DCA expenses incurred after the Plan Year ends are not reimbursable. Except as indicated above, no additional contributions to the Plan are allowed.

5. Flexible Benefits Plan Enrollment Form.

The Flexible Benefits Plan Enrollment Form shall be in a form which permits the Employer to reduce the Participant's current salary and contribute the amount of the reduction to purchase benefits on behalf of the Participant. The Flexible Benefits Plan Enrollment Form shall apply only to amounts of the Participant's pay that have not been actually or constructively received as of the date of the Flexible Benefits Plan Enrollment Form. Any amounts so elected shall not become currently available to the Participant. Each Participant may complete a Flexible Benefits Plan Enrollment Form which will reduce his or her salary by an amount equal to that necessary to provide for the type of coverage elected under this Plan. The amount of the Flexible Benefits Plan Enrollment Form elected by the Participant shall be deemed to be Employer contribution for purposes of the Code.

Each Plan Year, the Participant will be required to complete a new Flexible Benefits Plan Enrollment Form for the FSA expenses, LPFSA expenses and DCA expenses portions of the Plan. Failure to submit a completed Flexible Benefits Plan Enrollment Form during a designated open enrollment period to elect to participate in the FSA expenses, LPFSA expenses and DCA

expenses portions of the Plan, will not be able to participate in these portions of the Plan for that Plan Year (unless a Change of Status event occurred).

6. Revocation of Election.

Generally, once a Participant under the terms of the Plan has made a decision with respect to benefits, the Participant may not revoke that election during the Plan Year or the designated benefit plan year. A Participant may change his or her election during a Plan Year or during a designated benefit plan year in the following limited situations. Notification of a Change in Status must be made to Employer in writing within thirty (30) days of the event. Failure to notify the Employer in writing within thirty (30) days, the Participant must wait until the next annual open enrollment period to make an election change.

A. Changes in Status

1. Change in status events

A Participant may revoke an election during the Plan year or the designated benefit plan year and make a new election for the remaining period of coverage under the Plan if there is a change in status as described below and if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. The Plan Administrator shall determine whether a requested change is on account of and corresponds with a change in status.

- (a) Legal marital status. Events that change a Participant's legal marital status, including the following: marriage; death of spouse; divorce; legal separation; and annulment.
- (b) Number of dependents. Events that change a Participant's number of dependents, including the following: birth; death; adoption; and placement for adoption, as well as a Child becoming newly eligible for coverage or eligible for coverage beyond the date on which the Child otherwise would have lost coverage.
- (c) Employment status. Events that change the employment status of a Participant, a Participant's spouse, or a Participant's dependent, including the following: 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, and the switching from part-time to full-time employment status or from full-time to part-time status by a Participant or a Participant's spouse or dependent.
- (d) Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.
- (e) Residence. A change in the place of residence of a Participant, spouse or dependent.
Note: The change in residence must result in the Participant, Participant's spouse or dependent gaining or losing eligibility under a plan.

If the change in status is (a) a Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent or (b) a dependent ceasing to satisfy the eligibility requirements for coverage, then a Participant may only elect to cancel coverage for the affected spouse or dependent. Canceling coverage for any other individual under

these circumstances would fail to correspond with that change in status and therefore is not a permitted election change.

If a Participant, spouse or dependent gains eligibility for coverage under a plan sponsored by the employer of the Participant's spouse or dependent as a result of a change in Legal marital status or change in Employment Status, a Participant may change an election to cease or decrease coverage for that individual under the Plan only if coverage for that individual becomes applicable (i.e. effective) or is increased under the other employer's plan.

Applicability to DCA expenses portion of the Plan: An election change relating to the DCA expenses portion of the Plan is permitted only if (a) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan or (b) the election change is on account of and corresponds with a change in status that affects DCA expenses available under Section 129 of the Internal Revenue Code. (For example: A DCA expenses election may be canceled where a dependent child turns age 13 in the middle of the Plan Year).

B. Cost or Coverage Changes

1. Automatic increase or decrease for cost changes.

If the cost of a qualified benefits plan increases or decreases during a period of coverage, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Participants' elective contributions to reflect such cost changes.

2. Significant cost increases.

If the cost of a benefit package option (such as a PPO option or HMO option under a health plan) significantly increases during a period of coverage as determined by the Plan Administrator, a Participant may elect to make a corresponding prospective increase in his or her payments, or to revoke his or her election and, in lieu thereof, to receive on a prospective basis coverage under another benefit package option providing similar coverage.

Applicability to the DCA expenses portion of the Plan: A Participant in the DCA expenses portion of the Plan may change an election based upon a significant increase in cost of the dependent care provider only if the cost change is imposed by a dependent care provider who is not a relative of the Participant (For example, the Participant's parent(s), child(ren), brother(s), sister(s), etc.)

3. Coverage changes.

If the coverage under a plan is significantly curtailed or ceases during a period of coverage, an affected Participant may revoke his or her election and make a new election on a prospective basis for coverage under another benefit package option providing similar coverage. Coverage is considered significantly curtailed only if there is an overall reduction in coverage provided to participants under a plan so as to constitute reduced coverage to participants generally.

If a plan adds a new benefit package option or other coverage option (or eliminates an

existing benefits package option or other coverage option), an affected Participant may elect the newly-added option (or elect another option if an option has been eliminated) prospectively on a pre-tax basis and make a corresponding election change with respect to other benefit package options providing similar coverage.

Applicability to DCA expenses portion of the Plan: The availability of dependent care services from a new child care provider during the Plan Year does constitute a significant change in coverage similar to a benefit package option becoming available. Accordingly, a Participant is permitted to revoke his or her previous election under the DCA expenses portion of the Plan and make a corresponding new election to reflect the cost of the new child care provider. In addition, a change in the number of hours of work performed by a child care provider constitutes a change in coverage enabling a Participant to make a corresponding new election to reflect the new cost of the child care provider.

Applicability to the FSA or LPFSA expenses portion of the Plan: Election changes related to the FSA or LPFSA expenses portion of the plan are not permitted under this section B (Cost or Coverage Changes).

C. Other Permitted Mid-year Election Changes

1. Special Enrollment Rights under HIPAA

A Participant may revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. Judgment, Decree or Order.

The Plan may change a Participant's election to provide coverage for the Participant's child if a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for the child. If a judgment, decree or order requires a Participant's spouse, former spouse, or other individual to cover the child, the Participant may change his/her election to revoke coverage for the child.

3. Entitlement to Medicare or Medicaid

A Participant may change an election on a prospective basis to cancel or reduce coverage of the Participant or Participant's spouse or dependent under a plan if the Participant, Participant's spouse or dependent who is enrolled in a plan subsequently becomes enrolled under Part A or Part B of Medicare or entitled to Medicaid. Conversely, a Participant may change an election on a prospective basis to commence or increase coverage of the Participant or Participant's spouse or dependent if the Participant or Participant's spouse or dependent who had been entitled to Medicare or Medicaid subsequently loses eligibility for coverage under Medicare or Medicaid.

4. The Family and Medical Leave Act

A Participant taking leave under the Family and Medical Leave Act (FMLA) may revoke an existing election of group health plan coverage and make such other election for the

remaining portion of the period of coverage as may be provided for under the FMLA.

5. Change in Coverage of Spouse or Dependent under other Employer's plan

A Participant may change an election on a prospective basis that is on account of and corresponds with a change made under the plan of a spouse's or dependent's employer if (a) the plan of the spouse's or dependent's employer permits participants to make election changes that would be permitted under IRS regulations under Section 125 of the Code or (b) the Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the plan of the spouse's or dependent's employer.

6. Changes Allowed Under Current Regulations

A Participant may change an election on a prospective basis that is on account of and corresponds with any other permitted change under the current IRS regulations under Section 125 of the Code.

7. Reduction of Hours

A Participant may prospectively revoke an election for coverage (that is not a health FSA, but provides a minimum essential coverage) if they experience a change in employment status, such that 1) they are no longer expected to work an average of at least 30 hours of service per week, but 2) the reduction in hours does not result in the ceasing of the Participant to be eligible for coverage. The revocation of the election of coverage must correspond to the Participant's intent to enroll and any eligible dependents (who cease coverage due to the revocation) in another plan that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

8. Enrollment in a Qualified Health Plan through the Marketplace

A Participant may prospectively revoke an election for coverage (that is not a health FSA, but provides minimum essential coverage) if they are eligible for a special or annual enrollment period to enroll in a Qualified Health Plan through the Health Insurance Marketplace ("Marketplace") established under section 1311 of the Affordable Care Act. The revocation of the election of coverage must correspond to their intent to enroll and any eligible dependents (who cease coverage due to the revocation) in the Qualified Health Plan, the effective date for which is no later than the day immediately following the last day of coverage through their group health plan.

A Participant may prospectively revoke an election for family coverage (that is not a health FSA, but provides minimum essential coverage) if one or more already-covered related individuals are eligible for a special enrollment period to enroll in a Qualified Health Plan through the Marketplace, or one or more already-covered related individuals seek to enroll in a Qualified Health Plan during the Marketplace's annual open enrollment period. The revocation of coverage must correspond to the intended enrollment of the related individual(s) in the Qualified Health Plan for new coverage, the effective date for which is no later than the day immediately following the last day of the revoked coverage.

If a Participant revokes an election during the Plan Year or during a designated benefit plan year for any reason other than those specifically allowed by the Internal Revenue Code and the regulations thereunder, the amount of the Participant's contribution during that designated benefit plan year may be included in the Participant's gross income.

7. Choice of Benefits.

A Participant may make an election under the terms of the Plan with respect to any of the following benefits:

(a) Qualified Insurance Premiums

A Participant may allow the Employer to reduce his or her current salary pursuant to the applicable enrollment form(s) provided by the Employer and make premium payments for coverage under the Employer's qualified insurance plans. Premium payments shall be made directly by the Employer, and benefits shall be paid pursuant to the terms of the applicable plans. The benefit descriptions and all other provisions in such plans and any applicable contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

Such qualified insurance premiums apply to the Participant, the Participant's spouse or Participant's dependents (as defined in Section 152 of the Code), as well as the Participant's Children who have not attained age 27 as of the end of the taxable year.

(b) Health savings account (HSA) contributions

A Participant covered by a HSA-qualified high deductible health plan (HDHP), may allow the Company to reduce its current salary pursuant to the applicable enrollment form provided by the Company for contributions to a Health Savings Account (HSA). The Participant cannot be covered by another health plan, including Medicare, and the Participant cannot be claimed as a dependent on another individual's tax return.

- Medicare Enrollment: All HSA contributions must cease for the current Plan Year maximum contribution amount once a participant is enrolled in any type of Medicare.
- Full Plan Year's Contribution:
 - A full Plan Year's contribution may be made to an HSA if you become eligible under a qualified High Deductible Health Plan at anytime during the Plan Year.
 - If a Participant contributes a full Plan Year's contribution but is eligible for only part of the Plan Year, they will be subject to taxes and penalties if they don't remain a Participant in the Plan for 12 months after the Plan Year in which they first became eligible.
- Excess contributions:
 - Contributions to the HSA in excess of the contribution limits must be withdrawn by the participant or be subject to an excise tax.
 - A pro-rata portion of earnings must be withdrawn, also
 - Pay income tax on the withdrawn amount, but no 20% penalty

- If the HSA maximum contribution limit was not reached for the Plan Year, any other withdrawal for the Plan Year (that is not for qualified medical expenses) will not be considered “excess HSA contributions” and this withdrawal will be subject to both income tax and the 20% penalty.
- Contributions are pre-tax:
 - All HSA contributions through this Plan are “pre-tax” and are not subject to individual or employment taxes.

(c) Health Flexible Spending Account (FSA) Expenses

Participants in a Health Savings Account may not enroll in this portion of the Plan.

A Participant may allow the Employer to reduce his or her current salary pursuant to a Flexible Benefits Plan Enrollment Form and make payments on behalf of the Participant for the subsequent reimbursement of certain FSA expenses. The following health expenses may be submitted for reimbursement under the FSA expenses portion of the Plan:

- (1) Expenses for medical care as allowed by Section 213 of the Code.
- (2) Expenses incurred for medicines and drugs purchased without a prescription to alleviate or treat personal injuries or sickness if substantiated by a receipt showing, at a minimum, 1) the date purchased, 2) the amount of the purchase, and 3) the specific item(s) purchased.
- (3) Any other expense allowed by the IRS as reimbursable under a flexible spending account.

There are certain expenses that do not qualify. For example, you cannot obtain reimbursement for health club dues, non-prescription eyeglasses or sunglasses, programs or prescriptions to control weight (unless a medical necessity exists) and cosmetic procedures (including teeth bleaching, electrolysis, hair transplants and prescriptions or OTC drugs taken for cosmetic reasons) unless necessary because of injuries you receive or related to a congenital disfigurement.

Such expenses may be incurred by the Participant, the Participant’s spouse or the Participant’s dependents (as defined in Section 152 of the Code), as well as the Participant’s Children who have not attained age 27 as of the end of the taxable year. The expense will only be reimbursed to the extent that the Participant or other person is not reimbursed for the expense through any other insurance or other source. Any reimbursement to a Participant under this Plan may not otherwise be claimed as a credit or deduction under the Code.

The rules governing eligibility for the Plan are explained in Article III, the maximum amount of reimbursement is set forth in Article IV and the procedure for filing claims is stated in Article VII. All other provisions of the Plan apply to the medical expense reimbursement program as well.

(d) Limited purpose Flexible Spending Account (LPFSA) Expenses

This option is available to Employees enrolled in a Health Savings Account.

A Participant may allow the Company to reduce their current salary pursuant to a Flexible Benefits Plan Enrollment Form to make payments on their behalf for the subsequent reimbursement of certain health expenses. **Only vision, dental and preventive care expenses as specified by Sections 213 and 223 of the Code may be submitted for reimbursement through this portion of the Plan.**

Such expenses may be incurred by you, your spouse or your dependent. The expense will only be reimbursed to the extent that you or other person is not reimbursed for the expense through any other insurance or other source. Any reimbursement to you under this Plan may not otherwise be claimed as a credit or deduction under the Code.

The following medical expenses may be submitted for reimbursement under the LPFSA expenses portion of the Plan:

- (1) Expenses for vision care as allowed by Sections 213 and 223.
- (2) Expenses for dental care as allowed by Sections 213 and 223.
- (3) Expenses for preventive care.

Expenses for preventive care do not generally include any service or benefit intended to treat an existing illness, injury or condition. Preventive care includes, but is not limited to, the following:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs.
- Screening services, including:
 - Cancer Screening
 - Heart and Vascular Diseases Screening
 - Infectious Diseases Screening
 - Mental Health Conditions and Substance Abuse Screening
 - Metabolic, Nutritional, and Endocrine Conditions Screening
 - Musculoskeletal Disorders Screening
 - Obstetric and Gynecologic Conditions Screening
 - Pediatric Conditions Screening
 - Vision and Hearing Disorders Screening

(e) Dependent Care Assistance (DCA) Expenses

A Participant may allow the Employer to reduce his or her current salary pursuant to a Flexible Benefits Plan Enrollment Form and make payments on behalf of the Participant for the subsequent reimbursement of certain DCA expenses in accordance with Section 129 of the Code.

A Participant may request reimbursement for those dependent care expenses incurred in connection with the following qualifying individuals:

- i. A dependent of the Participant who is under age 13 and with respect to whom the Participant is entitled to a deduction under Section 151(c) of the Code.
- ii. A dependent of the Participant who is physically or mentally incapable of caring for himself or herself.
- iii. The spouse of the Participant, if he or she is physically or mentally incapable of caring for himself or herself.
- iv. Any other individual defined under Section 21(b) of the Code.

Expenses will only be reimbursed to the extent they allow the Participant and spouse, if any, to be gainfully employed. Such expenses include costs for the care of a qualifying individual described above and related household services.

Also, a Participant may request reimbursement for those expenses incurred outside the Participant's home for the care of a qualifying individual described in (1) above or for the care of those qualifying individuals described in (2) and (3) above if those individuals regularly spend at least eight (8) hours each day in the Participant's household.

Expenses incurred outside the Participant's home at a dependent care center are reimbursable only if such center complies with all applicable laws and regulations of the appropriate State or unit of local government or any other requirement under the Code.

Expenses paid to the spouse or other dependent of the Participant for the care of any qualifying individual are not reimbursable. Any reimbursement under this Plan may not otherwise be claimed as a credit or deduction under the Code. Notwithstanding the above, only expenses specifically allowed by Sections 21, 129 or any other related section of the Code will be reimbursed.

The rules governing eligibility for the Plan are explained in Article III, the maximum amount of reimbursement is set forth in Article IV and the procedure for filing claims is stated in Article VII. All other provisions of the Plan apply to the DCA program as well.

8. Uniform Coverage.

Under the FSA and LPFSA portion of the Plan only, the total amount of a Participant's elective annual contribution will be available for reimbursement at any time during the Plan Year.

9. Loss of Benefits.

If the Participant does not use all of the amounts contributed to the FSA or LPFSA portions

of the Plan during the Plan Year, the Participant will nonetheless be able to carryover up to \$640 of these unused amounts remaining at the end of the Plan Year (or at the end of the run-out period) for applicable FSA expenses incurred in the subsequent Plan Year. (As such, any unused amount in excess of \$640 that remains unused as of the end of the Plan Year (or at the end of the run-out period) is forfeited, and such amount will be returned to the Company.) However, if the Participant does not use all of the amounts they've contributed to the DCA portions of the Plan during the Plan Year or Grace Period, they will lose these amounts and they will be returned to the Company. Participants cannot commingle their salary reduction amounts among the various portions of the Plan. Therefore, Participants should be conservative in estimating their expenses.

The Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act"), allows military reservists called to active duty for a period of at least 180 days (or for an indefinite period of time) who are a Participant in the Plan to obtain distributions of their unused balances from their FSA and LPFSA. These distributions will be made during the period beginning on the date of the call to active duty, and end on the last date reimbursements could be made under the FSA or LPFSA for that Plan year. The Participant must notify the Human Resources Department by the last date reimbursements end for that Plan year to receive the distribution. The distribution is taxable to the Participant.

10. Notification.

The Employer shall communicate in writing to all Participants a summary of the terms and conditions of the Plan. The summary shall be interpreted in a manner consistent with this document. The summary plan description for this Plan is meant to be the summary plan description for the DCA plan as well.

11. Rights Against the Employer.

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

The establishment of the Plan, including any modifications thereto or distributions thereunder, shall not be construed as giving to any Participant or other person any legal or equitable right against the Employer, its shareholders, directors or officers.

12. Non-Alienation of Benefits.

No benefit payable under the provisions of any plan incorporated by reference into this Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge shall be void; nor shall such benefits be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Participant, dependent or beneficiary, including claims of creditors, claims of alimony or support, and any like or unlike claims.

13. Rights of Recovery, Reimbursement and Subrogation.

To the fullest extent permitted by law, the Employer reserves its rights of recovery,

reimbursement and subrogation as may be stated in any health or welfare plan incorporated by reference into this Plan. Accordingly, such provisions are by reference made a part of this Plan.

14. Taxation.

It is the Employer's intent that the benefits provided herein be deductible by the Employer under Section 162 of the Code and excludable from taxation by the Participant under Sections 105, 106 and 125 of the Code, as amended or supplemented, and all provisions herein shall be interpreted consistently with this intent. It is also the Employer's intent that the applicable amount be excludable from taxation under Section 79 of the Code.

It is the Employer's intent that the Plan be in compliance with Section 125 of the Code. This Plan, however, has not been and may not be submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that the intended tax benefits will be available. Any Employee, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus interest, if any, as may be imposed by the Internal Revenue Service.

ARTICLE V
ACCOUNTS AND RECORDS

The Employer shall establish and maintain accounts and records in the name of each Participant. Such records will show the Participant's choices under the Plan, salary reduction amounts and premium payments. The salary reduction of a Participant shall be made pursuant to a signed Flexible Benefits Plan Enrollment Form and in accordance with normal payroll practices.

ARTICLE VI
CONTRIBUTIONS AND FINANCING

All premium payments for coverage under the Plan shall be made directly by the Employer in accordance with the provisions of Article IV. Such premium payments shall be deemed to be a Employer contribution for purposes of the Code. No contributions shall be required of the Participant, except as otherwise specifically provided. The entire cost of this Plan shall be borne by the Employer.

ARTICLE VII
ADMINISTRATION

1. Fiduciaries.

The fiduciary shall be responsible for the management, control, operation and administration of the Plan and shall act solely in the interests of the Participants and their beneficiaries and in accordance with governing plan documents.

In exercising its fiduciary and other responsibilities, the Employer, as Plan Administrator and Plan Fiduciary, shall have the discretionary authority to determine eligibility for benefits, review any denied claims for benefits and construe disputed plan terms. The Employer shall be deemed to have properly exercised such authority, unless it has abused its discretion by acting arbitrarily and capriciously.

2. Administration.

The Employer shall administer the Plan and shall have the authority to exercise the powers and discretion conferred on it by the Plan and shall have such other powers and authorities necessary or proper for the administration of the Plan as shall be determined from time to time.

The Employer shall keep complete records and accounts necessary or proper to administer the Plan.

The Employer may adopt such rules and regulations for the administration of the Plan as it shall consider advisable and shall have full power and authority to enforce, construe, interpret and administer the Plan. All interpretations under this Plan and all determinations of fact made in good faith by the Employer shall be binding on the Participants, their beneficiaries and all other persons interested.

3. Claims Procedure.

Claims for benefits under any qualified insurance plans should be submitted in accordance with the procedures established by the applicable plans.

Participants may receive distributions from their Health Savings Account (HSA) at any time. Participants may withdraw funds by either using their debit card provided by the HSA custodian or trustee or by issuing a check from their HSA account.

Reimbursement claims for the FSA expenses or LPFSA expenses (non-Allied Flex Debit Card) and DCA expenses must be submitted in writing on the form provided. DCA expenses may only be reimbursed if the Participant provides a written statement stating that the expense has been incurred during the Plan Year or Grace Period, the amount of such expense and that the expense has not been reimbursed or is not reimbursable under any other plan. FSA expenses or LPFSA expenses may only be reimbursed if the Participant provides a written statement stating that the expense has been incurred during the Plan Year, the amount of such expense and that the expense has not been reimbursed or is not reimbursable under any other plan. A Participant is required to keep all receipts since they may be asked for the receipts in order to substantiate the claim. All such claims must be submitted within 90 days following the end of the Plan Year. Your failure to do so will result in the denial of the charges.

After a FSA, LPFSA, or DCA claim is processed, an electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination" and is subject to the provisions detailed below.

The Plan will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information.

A notice of Adverse Benefit Determination will include the following:

- ◆ The specific reason or reasons for the adverse determination.
- ◆ Reference to specific plan provisions on which the adverse determination is based.
- ◆ A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- ◆ If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- ◆ If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

4. Appeals.

A Participant or his or her authorized representative may appeal an Adverse Benefit Determination by filing a written application with the Plan. In appealing an Adverse Benefit Determination, the Plan will provide the Participant or his or her authorized representative:

- ◆ The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- ◆ Upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- ◆ A full and fair review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- ◆ A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- ◆ In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection

with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

- ◆ Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

An appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan will notify the Participant or his or her authorized representative of the Plan's determination within 60 days after receipt of an appeal.

The Plan's determination:

- ◆ will be in writing setting forth specific reasons for the decision and reference to the specific plan provisions upon which the determination is based.
- ◆ will contain a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- ◆ if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request.
- ◆ if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

5. Indemnification.

To the extent permitted by law, Employees of the Employer and all agents and representatives of the Employer, shall be indemnified by the Employer and saved harmless against any claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect or willful misconduct. The Employer reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

6. Expenses of Administration.

Any expense incurred by the Employer relative to the administration of the Plan shall be paid by the Employer.

7. Rights of the Employer to Inspect the Records of the Plan.

The Employer may at its own expense at any time cause an examination of the books and records of the Plan to be made by such attorneys, accountants, auditors or other agents as it shall select for that purpose and may cause a report of such examination to be made.

ARTICLE VIII

STANDARDS FOR PRIVACY AND SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED ("HIPAA")

A. Privacy Standards.

1. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI 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 PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in

Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

The Human Resources Manager, Staff designated by Human Resources Manager, Chief Financial Officer and Staff designated by Chief Financial Officer.

- ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” functions are activities that would meet the definitions of treatment, payment and health care operations. “Plan Administration” functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management and eligibility information requests. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

2. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

3. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

B. Security Standards.

1. Definitions.

- a. The term “Electronic Protected Health Information” (“E PHI”) has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.
- b. The term “Security Incidents” has the meaning set forth in Section 164.304 of

the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. Plan Sponsor Obligations.

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and
 - ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.
- e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

ARTICLE IX AMENDMENT AND TERMINATION

The Employer expects the Plan to be permanent, but since future conditions affecting the Employer cannot be anticipated or foreseen, the Employer must necessarily and does hereby reserve the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. The authority to make any such changes to the Plan rests with an authorized representative of the Employer. Any such amendment, modification, revocation or termination of the Plan shall be made by a written plan amendment signed by an authorized representative. The Employer may make modifications or amendments to the Plan that are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Code. The Plan shall not at any time be used for or diverted to purposes other than for the exclusive benefit of Participants or their beneficiaries, and no amendment shall divest any person of his or her interest therein, except as may be required by

the Internal Revenue Service or other governmental authority, or give any person any assignable or exchangeable interest or any right or thing of exchangeable value, in advance of the time distribution is to be made to such person. Notice of termination of, or material modifications to, the Plan shall be made in accordance with any applicable provisions of the Code. The termination of this Plan does not necessarily terminate any health or welfare plan incorporated by reference.

ARTICLE X
ILLEGALITY OF PARTICULAR PROVISION

The illegality or invalidity of any particular provision, or any portion of any provision, of this Plan shall not affect the other provisions, and the Plan shall be construed in all respects as if such invalid provision were omitted.

ARTICLE XI
EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an Employee, the contributions made for or on behalf of any Participant or the amount of distributions made or to be made to a Participant or other person, the Employer shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the contributions or distributions to which he or she is properly entitled under the Plan.

ARTICLE XII
OTHER PARTICIPATING EMPLOYERS

Upon the approval of the Employer, this Plan may be adopted by any affiliated organization (as defined in the Code). The adopting organization shall execute and deliver to the Employer a supplemental agreement providing for the adoption of this Plan and such other documents the Employer shall deem necessary or desirable. The provisions of this Plan shall be applicable to such organization to the extent provided in the supplemental agreement.

ARTICLE XIII
APPLICABLE LAWS

To the extent not preempted by federal law, the Plan shall be interpreted under the laws of the State of IL.

IN WITNESS WHEREOF, Community Consolidated School District #181 has caused this instrument to be executed, effective as of 1/1/2024.

By: _____

Title: Asst Supt of Business & Operations