

LEE'S SUMMIT R-7 SCHOOL DISTRICT

CAFETERIA PLAN

**Restatement
Effective April 15, 2021**

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ARTICLE I
USING THE PLAN DOCUMENT

1.1 **Introduction.** This is not just a summary of your Plan, but the actual Plan document written so that it can be used by you, the Plan's third-party administrator (the "TPA"), and the Employer in administering the Plan. In addition to this Article, which explains how to use the Plan document, the Plan has nine other articles. A brief summary of what you will find in each of them is given below.

1.2 **How to File a Claim.** Article II sets forth the Plan's claims and appeals procedure. The claim filing procedure has been streamlined as much as possible, and you now have several means of reimbursement available to you. Your cooperation in properly filing claims will help to avoid delays in paying your benefits.

1.3 **Coverage.** Article III explains the coverage rules of the Plan.

1.4 **Elections and Your Accounts.** Article IV describes how you make elections under the Plan and describes the maintenance of accounts on your behalf.

1.5 **Benefits Generally.** Article V describes the benefits provided by the Plan.

1.6 **Dependent Care Benefits.** Article VI describes the special rules that apply to dependent care benefits.

1.7 **Exclusions.** There are a number of exclusions which apply to all Plan benefits. Instead of repeating these each time a benefit is described, Article VII lists these exclusions.

1.8 **Administration of Plan.** Article VIII describes the functions of the Benefits Committee.

1.9 **General Provisions.** Article IX sets forth general provisions important to the administration of the Plan, including information the government requires be included in this document.

1.10 **Definitions.** Many of the terms used throughout the Plan are defined in Article X. Note that some very commonly used terms (such as "you") are specially defined in this article.

ARTICLE II

HOW TO FILE A CLAIM

2.1 Filing a Claim. If you elect the pre-tax payment of premiums for Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan coverage, you do not need to file a separate claim form. Payments of those premiums will automatically be deducted each month from your Premium Payment Account under this Plan. Any claim for benefits under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan will be decided in accordance with the provisions of that respective Plan.

There are several means of reimbursement from your General Medical Reimbursement Account, Limited Medical Reimbursement Account, and Dependent Care Account. You may use a debit card to make payments from your account, so long as you have funds available. You are not required to use the debit card to pay expenses, however. You can request reimbursement online, or print a claim form and send it in the mail or fax it to the TPA. All eligible expenses paid for with your debit card can be electronically validated. You must submit receipts or other documentation for tax purposes when additional validation of expenses is necessary.

If your employment with the Employer ends, you will be able to submit claims for reimbursement within 90 calendar days of your separation date for services provided up through the last day of the month of your separation.

If you elect to make pre-tax contributions to a Health Savings Account, your contributions will automatically be forwarded each month to the Plan's HSA provider. You will then request reimbursement directly from the HSA provider.

2.2 Decisions on Claims. The TPA will decide each claim within a reasonable time after it is received. You will be notified of all reimbursements and will receive an explanation of how the reimbursements were calculated. If a claim is wholly or partially denied, you will be furnished a written notice setting forth:

- (a) the specific reasons for the denial;
- (b) a specific reference to pertinent Plan provisions on which the denial was based;
- (c) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if you wish to seek a second-level appeal of your claim.

The TPA will notify you with regard to any denied claims due to inadequate substantiation or data submission, and will provide an adequate period of time for you to resubmit the claim.

2.3 First-Level Appeals. Within 180 days of receiving a notice that a claim was wholly or partially denied, you may appeal that denial to the TPA. You may also request access to all

relevant documents, in order to evaluate whether to file an appeal and, if so, to help prepare for that appeal.

The TPA will decide any appeal within 60 days of its receipt. The TPA will make no deference to the original denial, and any medical expert who is consulted in connection with your appeal will be different from, and not subordinate to, any expert consulted in connection with the original claim denial. If your first-level appeal is wholly or partially denied, you will be furnished a written notice setting forth:

- (a) the specific reasons for the denial;
- (b) a specific reference to pertinent Plan provisions on which the denial was based;
- (c) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if you wish to seek a second-level appeal of the denial.

2.4 Second-Level Appeals. The TPA will refer to the Employer, or its designee, the second-level appeal of any adverse benefit determination. Any request for a second-level appeal must be submitted to the TPA within 180 days after receipt of the denial of a first-level appeal. The Employer will decide any second-level appeal within 60 days of its receipt. If the Employer denies all or any portion of the appeal, the appeal decision will be made in writing and will include specific reasons for the decision, including specific references to the pertinent Plan provisions upon which the decision was based.

ARTICLE III
COVERAGE

3.1 **Commencement of Coverage.** Coverage under this Plan will begin at 12:01 a.m. on the day you become an Eligible Employee. In no event, however, will coverage commence before the Effective Date. This Section describes only when you become eligible to participate in the Plan. In order to contribute to an account, you must file an election in accordance with Article IV. To participate in the Health Savings Account feature of this Plan, you must be an HSA-Eligible Individual (see the definition of “HSA-Eligible Individual” in Article X).

3.2 **Termination of Coverage.** Your coverage under this Plan will terminate as of 12:01 a.m. on whichever of the following days occurs first:

- (a) the date you cease to be an Eligible Employee;
- (b) the date the Plan is terminated; or
- (c) the date you enter the armed forces on active duty.

Although elections made under this Plan automatically terminate as of the date you cease to be eligible to participate, you may continue to submit claims with respect to expenses incurred through the end of the month of your termination of participation. The deadline for submitting these claims is 90 days after the last day of the month in which you cease to be eligible to participate in the Plan.

3.3 **Continuation of Coverage.** As explained in Sections 4.9 and 4.10, you (or your Dependents) may elect to continue making contributions to your General or Limited Medical Reimbursement Account if coverage terminates due to an event listed in the federal “COBRA” statute. Those contributions would be made on an after-tax basis.

3.4 **HSA Contributions.** If you are an HSA-Eligible Individual and elect to make contributions to a Health Savings Account (or the Employer makes contributions on your behalf), you will not lose your rights to those contributions solely because your coverage under this Plan terminates.

ARTICLE IV

ELECTIONS AND YOUR ACCOUNTS

4.1 Your Accounts. You will have up to five bookkeeping accounts established to keep track of the number of benefit dollars available to you for reimbursement of covered expenses. These accounts are as follows:

(a) General Medical Reimbursement Account – used to keep track of the number of benefit dollars available to you for the reimbursement of Covered Medical Expenses.

(b) Limited Medical Reimbursement Account – used to keep track of the number of benefit dollars available to you for the reimbursement of Covered Dental and Vision Expenses.

(c) Premium Payment Account – used to keep track of the number of benefit dollars available to pay your premiums for coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan.

(d) Dependent Care Account – used to keep track of the number of benefit dollars available to you for reimbursement of Covered Dependent Care Expenses.

(e) HSA Account – used to keep track of the number of benefit dollars that will be forwarded to the Plan's HSA provider and deposited in your Health Savings Account.

Your General or Limited Medical Reimbursement Account will reflect the contributions you elect to have allocated to that account over the course of the entire Plan Year. Your other accounts will reflect the number of benefit dollars allocated to them each pay day, plus the dollars left in them from previous pay periods.

4.2 Health Savings Account. If you are eligible to do so, you may elect to participate in a Health Savings Account through this Plan. Such an Account would be established with a vendor selected by the Employer.

You are eligible to contribute to a Health Savings Account only if:

- You are an HSA-Eligible Individual (see the definition of this term in Article X);
- You are covered under a Qualified High Deductible Health Plan (as defined in Article X);
- You are not covered under a health plan or insurance policy (either as the primary insured or as a dependent) that is not a Qualified High Deductible Health Plan;
- You and your spouse are not contributing to a General Medical Reimbursement Account under this Plan or a similar health flexible

spending account under any other plan (such as a cafeteria plan sponsored by your spouse's employer);

- Neither you nor your spouse participates in an employer-sponsored health reimbursement arrangement, including the HRA Plan (other than a Limited HRA); and
- You have received no care or benefits, including prescription drugs, during the prior three-month period from the Department of Veteran's Affairs ("VA") or one of its facilities that would qualify as non-preventive care.

If you are an HSA-Eligible Individual, the Employer will make a contribution to your Health Savings Account in an amount the Employer will determine each year. (If you are covered under a Qualified High Deductible Health Plan but are *not* an HSA-Eligible Individual – for instance, because you are also covered under some other health plan that is not a Qualified High Deductible Health Plan – the Employer will instead make a contribution on your behalf to the HRA Plan.)

You may make additional contributions to a Health Savings Account through this Plan on a pre-tax basis. The Health Savings Account will be used to hold the contributions available to you for the reimbursement of qualified medical expenses, as defined in Section 223(d)(2) of the Code.

The Health Savings Account, itself, is not part of the Plan, and is established, administered, and maintained solely by the Plan's HSA provider pursuant to a trust or custodial agreement between you and the provider. The Employer's role is limited solely to verifying that you are an HSA-Eligible Individual and forwarding HSA contributions to the provider. The Employer has no authority or control over any funds after they are deposited in a Health Savings Account.

4.3 Salary Reduction Elections. The number of benefit dollars in your accounts will be determined by the number of dollars you elect to have taken from your pay. You may elect, during the 30-day period after your employment by the Employer, the amount (if any) you want taken from your pay during the remainder of the Plan Year and contributed to your accounts. Thereafter, you may elect during each annual open enrollment period the amount (if any) you want taken from your pay during the following Plan Year and contributed to your accounts. You may choose not to have your pay reduced, in which case no benefit dollars would be in your accounts. If you elect to contribute to a Health Savings Account, you may not also contribute (or have contributions made on your behalf) to the General Medical Reimbursement Account.

4.4 Amount of Reduction. If you elect to have a portion of your pay contributed to your accounts, you must elect separately the amount to be contributed to your General or Limited Medical Reimbursement Account, the amount to be contributed to your Premium Payment Account, and the amount to be contributed to your Dependent Care Account. For 2021, the maximum amount you may contribute each year to your accounts is as follows:

General Medical Reimbursement Account – \$2,750¹

Limited Medical Reimbursement Account – \$2,750¹

Premium Payment Account Your cost of coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, and Vision Plan

Dependent Care Account \$5,000 (For 2021 only, \$10,500, including any 2020 carryover amount under Section 4.14)²

The maximum amount that may be contributed on your behalf (by you, the Employer, or anyone else) each year to the Health Savings Account described in Section 4.2 is determined annually by the Internal Revenue Service. For 2021, that limit is \$3,600 (if you have single coverage under a Qualified High-Deductible Health Plan) or \$7,200 (if you have family coverage under a Qualified High-Deductible Health Plan). You may make an additional “catch-up contribution” (\$1,000 for 2021) if you are age 55 or older.³

The amount you elect to contribute to your Premium Payment Account will be adjusted automatically in the event of a change in your cost for the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan. For example, if you switch from full-time to part-time employment (or vice versa), the amount taken from your pay and contributed to your Premium Payment Account will be determined by the new cost of the coverage you chose for the Plan Year.

The amount you elect to contribute to your accounts will be taken from your pay for the Plan Year in equal installments (each pay period). Your pay will be reduced beginning with your January paycheck and ending with the following December’s paycheck. You may, if you choose, elect to have contributions to your Dependent Care Account taken from your first five paychecks and the last four paychecks for the Plan Year (in equal installments).

4.5 Absence of Election. If you do not file an election during the first 30 days after you become an Eligible Employee, you will be considered to have elected not to have your pay reduced during the remainder of that Plan Year. Similarly, if you do not file an election (or a new election) during any subsequent annual enrollment period, you will be considered to have elected not to

¹ You may contribute a *total* of only \$2,750 to your General and/or Limited Medical Reimbursement Account for the Plan Year. This limit may be adjusted from time to time by the Internal Revenue Service. If you are married, and your spouse is also an Eligible Employee, you may *each* contribute a total of \$2,750 to your respective General and/or Limited Medical Reimbursement Accounts for the Plan Year.

² If you are married and will file a separate federal income tax return for the year (as opposed to a joint return with your spouse), you may contribute only \$2,500 (for 2021 only, \$5,250, including any 2020 carryover amount under Section 4.14) to your Dependent Care Account. You may not contribute more than half of your pay to your Dependent Care Account. If you are married, you may not contribute more than your spouse’s earned income for the year.

³ The dollar amounts shown in this paragraph may be updated from time to time to reflect changes in the cost of living. Any such changes will automatically apply under this Plan.

have your pay reduced during the following Plan Year. You will therefore have no benefit dollars in your accounts during that year with which to pay benefits under this Plan.

4.6 New Eligible Employees. As soon as practicable after you become an Eligible Employee, Business Services will provide you with an election opportunity. If you wish to have amounts contributed on your behalf to the accounts described in Section 4.1, you must so specify in your election and agree to a reduction in your pay as provided in Section 4.3. You must complete your election by the date provided by Business Services.

4.7 Changing Elections During the Plan Year. Except as provided in this Section 4.7, elections you have made under Section 4.3 or 4.6 (or are *deemed* to have made under Section 4.5) may not be revoked or modified during a Plan Year. With respect to your Premium Payment Account, you may revoke an election made for the balance of a Plan Year, and then make a new election with respect to that account, if and only if *any* of the following circumstances applies. You may revoke an election to contribute to your Health Savings Account for the balance of a Plan Year at any time, and then make a new election (or no election) with respect to that Account. You may revoke or modify an election made with respect to your Dependent Care Account and/or your General or Limited Medical Reimbursement Account in *many*, but *not all*, of the following circumstances.

(a) HIPAA Special Enrollment. You may revoke an election made with respect to your Premium Payment Account if the revocation and new election correspond with a “special enrollment” right under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). You may not revoke an election made with respect to your Dependent Care Account or your General or Limited Medical Reimbursement Account in this circumstance.

(b) Child Support Order. You may revoke an election made with respect to your Premium Payment Account or your General or Limited Medical Reimbursement Account if, pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody, either:

(1) You are required to provide health coverage for your child, in which event you may elect, or may be *required*, to begin contributing to the Plan on behalf of that child, or

(2) Your former spouse is required to provide health coverage for your child, in which event you may revoke an existing election to contribute to this Plan on behalf of that child.

You may not modify an election made with respect to your Dependent Care Account in this circumstance.

(c) Medicare or Medicaid. You may revoke an election made with respect to your Premium Payment Account or your General or Limited Medical Reimbursement Account if you, your spouse, or your child either gain or lose entitlement to benefits under

either Medicare or Medicaid. You may not revoke or modify an election made with respect to your Dependent Care Account in this circumstance.

(d) Change in Status. You may revoke an election made with respect to your Premium Payment Account, General or Limited Medical Reimbursement Account, or Dependent Care Account if you experience a “change in status” (as defined in (1), below), and the election change is “consistent with” that change in status (as described in (2), below).

(1) A “change in status” includes any of the following:

(A) A change in your legal marital status – whether through marriage, divorce, legal separation, annulment, or death of your spouse;

(B) A change in the number of your Dependents – including the birth, adoption, placement for adoption, or death of a Dependent;

(C) The termination or commencement of employment by you, your spouse, or your child;

(D) A reduction or increase in the hours or employment worked by you, your spouse, or your child – including a switch between part-time and full-time status, a strike or lockout, or the commencement of, or return from, an unpaid leave of absence;

(E) An event that causes your Dependent to satisfy or cease to satisfy the requirements for coverage under any plan – whether due to the attainment of a specified age, student status, or any similar circumstance described in such plan; or

(F) A change in your place of residence or work, or in the place of residence or work of your spouse or child;

(G) Your enrollment in a plan through the Federal Marketplace or Exchange.

(2) An election change is “consistent with” a change in status if and only if:

(A) The change in status results in you, your spouse, or your child gaining or losing eligibility for coverage under any plan, and

(B) The election change corresponds with that gain or loss of coverage.

(e) Change in Cost. You may modify an election made with respect to your Premium Payment Account or Dependent Care Account in the event of a change in the cost of coverage, in accordance with the following rules:

(1) Premium Payment Account. If the cost of coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan either increases or decreases, your pre-tax contributions through this Plan will automatically increase or decrease to conform to that new cost; provided, however, that if there is a significant increase or a significant decrease in the cost of a benefit option under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan you may:

(A) Elect to begin participating in this Plan with respect to a benefit option for which there is a significant *decrease* in cost (if you had not been participating in the Plan with respect to that option before); or

(B) Revoke your election under the Plan with respect to a benefit option for which there is a significant *increase* in cost and, in lieu thereof, either:

(i) Elect coverage under another benefit option providing similar coverage, or

(ii) Drop coverage under the Plan with respect to that benefit option, but only if no other benefit option providing similar coverage is available.

(2) Dependent Care Account. You may revoke an election and make a new election, under your Dependent Care Account if the change in election corresponds to an increase or decrease in the cost of dependent care for which you seek reimbursement under Article VII of this Plan. This provision applies only if the change in cost is imposed by a dependent care provider who is not related to you.

(3) General or Limited Medical Reimbursement Account. You may not revoke or modify an election made with respect to your General or Limited Medical Reimbursement Account in this circumstance.

A “benefit option,” for purposes of this Subsection, means a benefit provided under this Plan or, with respect to your coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan an option or a type of coverage (such as HMO, PPO, or indemnity coverage).

A “change in the cost of coverage” means an increase or decrease in the amount you must pay for the benefit, whether as a result of your own actions (such as switching between full-time and part-time status) or an employer’s actions (such as reducing the amount of employer contributions for a benefit).

(f) Change in Coverage. Your election made with respect to your Premium Payment Account or Dependent Care Account may be modified as follows in the event of a change in coverage:

(1) Premium Payment Account. If coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan is significantly reduced, you may change your election as follows:

(A) Significant Reduction With Loss of Coverage. If the reduction amounts to a loss of coverage under a benefit option for you or your Dependent(s), you may revoke your election under the Plan with respect to that benefit option and, in lieu thereof, either:

(i) Elect coverage under another benefit option providing similar coverage, or

(ii) Drop coverage under the Plan with respect to that benefit option, but only if no other benefit option providing similar coverage is available.

(B) Significant Reduction Without Loss of Coverage. If the reduction does *not* amount to a loss of coverage under a benefit option for you or your Dependent(s), you may revoke your election under the Plan with respect to that benefit option and, in lieu thereof, elect coverage under another benefit option providing similar coverage.

(C) Loss of Coverage. A “loss of coverage,” for these purposes, generally means a complete loss of coverage under the benefit option, including, but not limited to:

(i) Elimination of a benefit option;

(ii) An HMO ceasing to be available in the area where you live;

(iii) Loss of all coverage under a benefit option due to an overall lifetime or annual limit;

(iv) A substantial decrease in the medical care providers available under a benefit option; or

(v) A reduction in benefits for a specific type of medical condition or treatment with respect to which you or your Dependent is currently undergoing a course of treatment.

(2) Dependent Care Account. You may revoke an election and make a new election under your Dependent Care Account if your need for dependent care from your existing dependent care provider is significantly reduced or eliminated, and the new election corresponds to that reduction or elimination.

(3) General or Limited Medical Reimbursement Account. You may not revoke or modify an election made with respect to your General or Limited Medical Reimbursement Account in this circumstance.

(g) New Benefit Option. Your elections under the Premium Payment Account or General or Limited Medical Reimbursement Account may be modified as follows in the event of a change in benefit options:

(1) Medical Premium Account. If a benefit option is added to the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan or if an existing benefit option under such Plan is significantly improved, you may elect to pay through this Plan any premium required for coverage under that new or improved benefit option.

(2) Dependent Care Account. You may revoke an election, and make a new election, with respect to your Dependent Care Account if you change child care providers and the new election corresponds to the change in care provider.

(3) General or Limited Medical Reimbursement Account. You may not revoke or modify an election made with respect to your General or Limited Medical Reimbursement Account in this circumstance.

(h) Change Under Other Employer's Plan. You may revoke an election made with respect your Premium Payment Account or Dependent Care Account (but *not* your General or Limited Medical Reimbursement Account) if a change in coverage is elected under another employer health care or cafeteria plan (including a plan sponsored by the Employer), but only if either of the following is true:

(1) The election under the other plan is made under rules similar to those described in this Section 4.7, or

(2) The plan year under the other plan differs from the Plan Year of this Plan.

(i) Change Under Governmental or Educational Institutional Plan. You may elect to increase (but *not* to decrease or eliminate) your contributions to your Premium Payment Account or Dependent Care Account (but *not* your General or Limited Medical Reimbursement Account) if you or your Dependent loses coverage under a group health plan sponsored by a governmental or educational institution, such as the Children's Health Insurance Program (CHIP). If you have not been participating in this Plan with respect to a benefit option before, you may elect to begin participating in that benefit option (on a prospective basis) in these circumstances.

(j) Reduction in Hours of Service. You may revoke an election made with respect to Medical Plan coverage under your Premium Payment Account if the revocation and new election correspond with your reduction in hours of service. The following conditions apply:

(1) You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you losing eligibility under the Medical Plan; and

(2) The revocation of the election of coverage under the Medical Plan corresponds to the intended enrollment of you (and any Dependents who lose coverage due to the revocation) in another plan that provides minimum essential coverage, with that new coverage effective no later than the first day of the second month following the month that includes the date the coverage is revoked.

You may not revoke an election with respect to any of your other coverages under the Premium Payment Account, either of the Medical Reimbursement Accounts, the Dependent Care Account, or the HSA Account in this circumstance.

(k) Qualified Health Plan Enrollment. You may revoke an election made with respect to Medical Plan coverage under your Premium Payment Account if the revocation and new election correspond with your enrollment in a qualified health plan. The following conditions apply:

(1) You either (a) are eligible for a special enrollment period to enroll in a qualified health plan through a Marketplace, pursuant to guidance issued by the Department of Health and Human Services, or (b) seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the Medical Plan corresponds to the intended enrollment of you (and any Dependents who lose coverage due to the revocation) in a qualified health plan through a Marketplace, with that new coverage to be effective beginning no later than the day immediately following the last day of the coverage that is revoked.

You may not revoke an election with respect to any of your other coverages under the Premium Payment Account, either of the Medical Reimbursement Accounts, the Dependent Care Account, or the HSA Account in this circumstance.

“Marketplace” means a competitive public marketplace or exchange established pursuant to the Affordable Care Act through which individuals may purchase health insurance coverage.

A “qualified health plan,” for purposes of this subsection, means a health plan available through a Marketplace.

(l) 2021 Temporary COVID-19 Relief. For 2021 only, if you previously elected to contribute to your Dependent Care Account for the 2021 Plan Year, you may elect to increase your contributions to your Dependent Care Account on a prospective

basis, up to the maximum amount set forth in Section 4.4, provided that you make such an election by May 19, 2021.

Any new election made under this Section 4.7 must be received by Business Services within 31 days after the occurrence of the event permitting the change. Notwithstanding the preceding sentence, the 31-day limit will be extended to sixty (60) days if you or a Dependent either (i) become(s) eligible for premium assistance under Medicaid or CHIP (a “HIPAA Special Enrollment” event under Paragraph 4.7(a)), or (ii) become(s) ineligible for coverage under Medicaid or CHIP (as described in Paragraph 4.7(i)). Such a new election will be effective with the first pay period beginning after a properly completed election form is received by Business Services, except that any new election attributable to the birth, adoption, or placement for adoption of a child will be effective as of the date of such birth, adoption, or placement for adoption.

4.8 Forfeitures. Amounts contributed to your Premium Payment Account will be used immediately to pay your premiums. Similarly, amounts contributed to your HSA Account will be forwarded to the Plan’s HSA provider. There should thus be no risk of your forfeiting amounts allocated to these accounts.

You need not use all of the contributions in your General or Limited Medical Reimbursement Account and Dependent Care Account during a month; amounts not used will remain in these accounts for later use during the year. However, as required under the Tax Code, you will forfeit all contributions in these accounts at the end of the Plan Year unless (i) within 90 days after the end of the Plan Year, you submit claims for payment of expenses incurred during the Plan Year that just ended (and that were incurred by the end of the month in which you last contributed to that account), or (ii) you qualify for a Qualified Reservist Distribution, as defined in Section 5.10. Any forfeited contributions will be used to help defray the expenses of Plan administration.

4.9 Termination of Employment. If you terminate your employment while you have a balance in your Dependent Care Account or your General or Limited Medical Reimbursement Account, you may continue to file claims for reimbursement from those accounts, but (except as provided in the following paragraph) only for covered expenses incurred through the end of the month in which your employment terminated. All claims for payment of those expenses must be submitted within 90 calendar days after the date on which your employment terminates.

You may continue to submit claims for reimbursement from your General Medical Reimbursement Account for Covered Medical Expenses, or from your Limited Medical Reimbursement Account for Covered Dental and Vision Expenses, incurred through the end of the Plan Year in which you terminate employment by electing to continue making contributions to your account for the remainder of that Plan Year. Your contributions would be equal to the amount previously taken from your pay (plus an additional 2% of that amount, as an administrative fee), but they would not be made on a pre-tax basis. Your ability to extend benefits in this fashion would be governed by the federal coverage continuation rules known as “COBRA.” The full set of COBRA rules would apply to your continued ability to use your General or Limited Medical Reimbursement Account, except that you would not be permitted to contribute to, or to make claims against, your General or Limited Medical Reimbursement Account for a period extending

beyond the end of the Plan Year in which you terminate employment. These COBRA rules are described in Appendix A.

If you terminate your employment, you will no longer be able to make contributions to your HSA Account through this Plan. However, because your Health Savings Account is established and maintained outside this Plan, you may continue to make contributions and seek reimbursement from your Health Savings Account in accordance with the trust or custodial agreement between you and the Plan's HSA provider. Because any such post-termination contributions will not be made through this Plan, they will have to be made on an after-tax basis.

4.10 Death. If you die while you have a balance in your Dependent Care Account or your General or Limited Medical Reimbursement Account, your Dependents may submit claims for reimbursement, but only for covered expenses incurred through the end of the month in which you die. Claims for payment of those expenses must be submitted within 90 calendar days after the date on which you die.

Moreover, your surviving Dependents may continue to submit claims for reimbursement from a General Medical Reimbursement Account (for Covered Medical Expenses) or from your Limited Medical Reimbursement Account (for Covered Dental and Vision Expenses) *they* incur by electing to make contributions to their *own* General or Limited Medical Reimbursement Accounts. Your Dependents' contributions would be equal to the amounts previously taken from your pay (plus an additional 2% of that amount, as an administrative fee), but they would not be made on a pre-tax basis. Your Dependents' right to extend benefits in this fashion would be governed by the COBRA rules, except that this right would apply only through the end of the Plan Year in which you die. These COBRA rules are described in Appendix A.

4.11 Authorized Leave of Absence. You may also have a right to continue coverage for yourself and your Dependents under the General or Limited Medical Reimbursement Account portion of this Plan during a period when you are on an authorized leave of absence (including a leave of absence authorized under the Family and Medical Leave Act). Your right to continue coverage during such a leave of absence, and the manner in which that coverage would be continued, is described in Appendix B.

4.12 Military Leave of Absence. Federal law ensures that you may continue coverage for yourself and your Dependents while on leave for the purpose of military training or service. For more information concerning your right to continued coverage during such a leave, please contact Business Services. If you are ordered or called to active duty, you may also be eligible for a "Qualified Reservist Distribution" from your General or Limited Medical Reimbursement Account during the Plan Year in which you are ordered or called. The rules and procedures for such distributions are explained in Section 5.10.

4.13 Medical Child Support Orders. Medical child support orders, typically issued in divorce proceedings, may create or recognize the right of a child of an Employee to be covered under the General or Limited Medical Reimbursement Account portion of this Plan. Such an order must be "qualified" in order for this Plan to be bound by it. Please contact Business Services for a copy of the written procedures the Plan follows to determine whether a medical child support order is qualified.

4.14 Temporary Carryover Relief. Notwithstanding the forfeiture rules of Section 4.8, unused benefit dollars remaining in your Dependent Care Account (but not your General or Limited Medical Reimbursement Account) at the end of the 2020 Plan Year may be carried over and used to reimburse expenses you incur during the 2021 Plan Year. Such carryovers are subject to the following conditions:

(a) Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will count toward the maximum dollar limit on annual salary reductions under the Dependent Care Account.

(b) Covered Dependent Care Expenses incurred in the 2021 Plan Year will be reimbursed first from your unused amounts credited for the 2021 Plan Year and then from amounts carried over from the 2020 Plan Year. Carryovers that are used to reimburse a 2021 Plan Year expense will reduce the amount available to pay your 2020 Plan Year expenses during the run-out period.

(c) Any carryover amount remaining at the end of the 2021 Plan Year will be forfeited.

ARTICLE V

BENEFITS – GENERAL DESCRIPTION

5.1 Benefits. You may choose to receive your full pay or to have a portion of it applied to pay any required premiums for coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan or to reimburse you for Covered Medical Expenses or Covered Dependent Care Expenses, or contributed to your HSA Account.

5.2 Payment of Benefits. The Plan will pay benefits as follows:

(a) Premium Payment Accounts. If you elect to contribute to the Premium Payment Account, those contributions will automatically be used to pay your premiums for coverage under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan. You do not need to take any action to request such a payment of premiums.

(b) HSA Account. Any amounts you or the Employer contributes to your HSA Account will be forwarded to the Plan's HSA provider, where it will be deposited into your Health Savings Account. You must request reimbursements directly from the HSA provider.

(c) General Medical Reimbursement Account. When you have a Covered Medical Expense, as described below, the TPA will, at your request, reimburse you from your General Medical Reimbursement Account for that expense. Your General Medical Reimbursement Account will be reduced by the amount of the reimbursement. The TPA will pay up to the amount you have elected to contribute to your account for the Plan Year.

(d) Limited Medical Reimbursement Account. When you have a Covered Dental or Vision Expense, as described below, the TPA will, at your request, reimburse you from your Limited Medical Reimbursement Account for that expense. Your Limited Medical Reimbursement Account will be reduced by the amount of the reimbursement. The TPA will pay up to the amount you have elected to contribute to your account for the Plan Year. (Note that Covered Dental or Vision Expenses are a type of Covered Medical Expenses and are therefore reimbursable from your General Medical Reimbursement Account, as well.)

(e) Dependent Care Account. When you have a Covered Dependent Care Expense, as described below, the TPA will, at your request, reimburse you from your Dependent Care Account for that expense. The TPA will not pay you more than the amount which is in your account at the time the payment is made. Your Dependent Care Account will be reduced by the amount of the reimbursement.

(f) Coordination with HRA Plan. Reimbursements for a Covered Medical Expense or a Covered Dental or Vision Expense will be made from your General or Limited Medical Reimbursement Account before any amounts held in an HRA Account under the HRA Plan are used to make such reimbursements.

(g) Debit and Credit (Stored Value) Cards. Subject to Section 2.1 and the following terms, you may, subject to any procedures established by the TPA, use a debit and/or credit (stored value) card (“Card”), provided by the TPA, to make payments from your General or Limited Medical Reimbursement Account.

(1) Card Only for a Covered Medical, Dental, or Vision Expenses. When you are issued a Card, you must certify that the Card will be used only for a Covered Medical, Dental, or Vision Expense. You must also certify that any Covered Medical, Dental, or Vision Expense paid with the Card has not already been reimbursed by any other plan covering health benefits, and that you will not seek reimbursement from any other plan covering health benefits.

(2) Card Issuance. A Card will be issued when you first begin participating in the General or Limited Medical Reimbursement Account, and then reissued for each Plan Year that you participate. The Card will be automatically cancelled upon your death or termination of participation, or if you have a change in status that results in your withdrawal from the General or Limited Medical Reimbursement Account.

(3) Maximum Dollar Amount Available. The dollar amount of coverage available on the Card will be the amount you elect to contribute to your General or Limited Medical Reimbursement Account for the Plan Year. The maximum amount of coverage available will be the maximum amount for the Plan Year, as set forth in Section 4.4.

(4) Only Available for Use with Certain Service Providers. The Card will be accepted only by the merchants and service providers that have been approved by the TPA.

(5) Card Use. The Card may be used only for a Covered Medical, Dental, or Vision Expense incurred at the merchants and providers approved by the TPA, including, but not limited to, the following:

- (A) Co-payments for doctor or other medical care;
- (B) Purchase of drugs (including over-the-counter drugs) or insulin; and
- (C) Purchase of medical items such as eyeglasses, syringes, and crutches.

(6) Substantiation. Purchases using the Card will be subject to substantiation by the TPA, usually by submission of a receipt from a service provider describing the service, the date, and the amount. The TPA will also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges will be conditional pending confirmation and substantiation.

(7) Correction Methods. If a Card purchase is later determined by the TPA to not qualify as a Covered Medical, Dental, or Vision Expense, the TPA, in its discretion, will use one of the following correction methods to make the Plan whole:

(A) Repayment of the improper amount by you;

(B) Asking the Employer to withhold the improper payment from your compensation, to the extent consistent with applicable federal or state law; or

(C) Claims substitution or offset of future claims until the amount is repaid.

If subsections (A) through (C) fail to recover the full amount, the Employer may treat the unrecovered amount as any other business indebtedness and you may incur adverse tax consequences. Until the amount is repaid, the TPA will take action to ensure that further violations of the terms of the Card do not occur, up to and including denial of access to the Card.

5.3 Covered Medical Expenses.

(a) In General. Except as provided in Paragraph (c), below, Covered Medical Expenses are amounts you pay (for yourself or your Dependents) as deductibles or co-payment amounts under a health plan, as well as other charges (other than insurance premiums) for medical care, as that term is defined in Section 213(d) of the Tax Code. In general, this term includes the diagnosis, cure, mitigation, treatment, or prevention of a disease or injury.

(b) Examples. The following are examples of Covered Medical Expenses, but only if the expenses are incurred by you or your Dependents and neither you nor your Dependents are reimbursed for the expenses from another health plan or policy:

- Acupuncture services connected with the diagnosis, cure, mitigation, treatment, or prevention of disease
- Ambulance expenses
- Chiropractors' fees
- Dental care
- Diagnostic Services, including laboratory and X-ray services
- Eye glasses and contact lenses
- Hospital bills
- Insulin
- Medical appliances, such as artificial teeth or limbs, crutches, elastic stockings, and hearing aids
- Non-prescription drugs that are legally procured, such as antacids, allergy medicines, pain relievers, and cold medicines.
- Nurses' fees

- Operations
- Oxygen equipment and oxygen
- Physicians' fees
- Prescription drugs
- Psychiatric care
- Psychologists' fees
- Smoking Cessation programs
- Surgical fees

(c) Limitations and Exclusions. The following expenses do not constitute Covered Medical Expenses, and will therefore not be subject to reimbursement from a Medical Reimbursement Account, even if they constitute medical care:

- Expenses for long-term care services
- Expenses for cosmetic surgery, unless directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- Premium payments for other health coverage (e.g., premiums paid for health coverage under a plan maintained by a spouse's employer)
- Expenses for items that are merely beneficial to general good health (e.g. vitamins), or for toiletries (e.g. toothpaste) or cosmetics (e.g., face cream)

5.4 Covered Dental and Vision Expenses.

(a) In General. Covered Dental and Vision Expenses are Covered Medical Expenses that pertain to dental and vision care.

(b) Examples. The following are examples of Covered Dental and Vision Expenses, but only if the expenses are incurred by you or your Dependents and neither you nor your Dependents are reimbursed for the expenses from another health plan or policy:

(1) Non-Cosmetic Dental Care

- Bridges
- Crowns
- Dental reconstruction
- Dental Prescriptions
- Dentures
- Dental x-ray fees
- Teeth grinding prevention device

(2) Orthodontia

- Braces
- Expenses related to orthodontia

(3) Vision Care

- Solutions and supplies for contact lenses
- Contact lenses
- Eye exams
- Eye Care Prescriptions
- Eyeglasses
- Guide dog (dog, training, care)
- Keratotomy
- Lasik
- Prescription sunglasses
- Optometrist fees
- Vision correcting eye surgery or treatment

5.5 Covered Premium Payment Expenses. Covered Premium Payment Expenses are amounts you are required to contribute to receive coverage (for yourself or your Dependents) under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan. The requirements for participating in the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan, and the other terms and conditions of coverage and benefits under those plans are as set forth from time to time in those plans, and in the group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference in) those plans. The benefit descriptions in the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, and Vision Plan and the contracts, as in effect from time to time, are incorporated by reference into this Plan. The manner in which you make claims, and the appeals procedure, under each plan are set forth in the booklets you receive describing benefits under those plans.

5.6 Covered Dependent Care Expenses. A Covered Dependent Care Expense is an expense incurred by you that is covered under the Dependent Care Expense Plan set forth in the following article of this Plan.

5.7 Tax Consequences of Plan Participation. This Plan is intended to be a “cafeteria plan,” as described in Section 125 of the Tax Code. By structuring the Plan in this manner, you should realize substantial tax savings on the amounts you contribute to your accounts. In general, those amounts will not be subject to federal or state income taxes, or to Social Security taxes. Although the Employer *believes* the Plan complies with Section 125, and that it therefore provides these tax benefits, there is currently no procedure whereby the Employer can submit the Plan to the Internal Revenue Service for its approval. There can thus be no guarantee that the intended tax benefits will be available to you.

5.8 Effect of Election on Social Security Benefits. By participating in this Plan, you not only avoid federal and state income taxation on the amounts you contribute to your accounts, you also avoid F.I.C.A. (Social Security) taxation on those amounts. This can be both good and bad. Your take home pay will be larger, but the wages taken into account when computing your Social Security retirement benefit will be reduced. For some employees, the effect will be to receive a slightly smaller Social Security retirement benefit than they would if they did not participate in this Plan.

5.9 Nondiscrimination Rule. The Tax Code includes rules prohibiting discrimination under plans of this kind in favor of certain officers, shareholders, and highly compensated participants. If, at any time during a Plan Year, it appears that this nondiscrimination rule may be violated, the Employer or its designee may reduce or reject any contribution election made by such a participant.

5.10 Qualified Reservist Distributions. A Qualified Reservist Distribution (or “QRD”) is an exception to the general rule that unused contributions in your General or Limited Medical Reimbursement Account will be forfeited if you fail to submit claims by the deadline specified in Section 4.8. The amount of any QRD will, instead, be distributed to you and included in your taxable income for the year in which you receive it.

(a) Eligibility. You are eligible for a QRD if (i) you are ordered or called to active duty for a period of at least 180 days (including any extensions) or for an indefinite period, and (ii) you provide the Employer with a copy of the order or call to active duty.

(b) Procedure. QRD requests must (i) be in writing, (ii) include a copy of the document ordering or calling you to active duty, and (iii) be received by Business Services no earlier than the date you are ordered or called to active duty and no later than the deadline under Section 4.8 for filing a claim for expenses incurred during the Plan Year in which the order or call occurred. The QRD will be paid to you within a reasonable time, but no later than sixty (60) days after your request is received by Business Services.

(c) Effect on Other Claims. If you request a QRD, you will still be able to submit claims for reimbursement from your General or Limited Medical Reimbursement Account for expenses incurred before the date you request a QRD, but not for expenses incurred after that date.

(d) Amount. If you are eligible for a QRD, you may withdraw the amount you have contributed to your General or Limited Medical Reimbursement Account during the Plan Year, less any reimbursements you have already received for that Plan Year.

ARTICLE VI

DEPENDENT CARE BENEFITS

6.1 Dependent Care. The TPA will pay benefits from your Dependent Care Account for expenses you incur for dependent care or household services which enable you to be gainfully employed. The dependents for whom the care or household services may be provided are:

(a) your Eligible Child or Children under the age of 13 (or, solely for the 2020 Plan Year (including any carryover amounts under Section 4.14), age 14) for whom you are entitled to take a dependent deduction on your federal income tax return, or

(b) your spouse, parents, grandparents, great grandparents, step-parents, aunts, uncles, or Eligible Children age 13 or over, if they are physically or mentally incapable of caring for themselves and you provide over half of their financial support for the year (except you need not provide over half of the support for your spouse).

6.2 Care Providers. Dependent care may be provided either in your home or outside of your home. If the care is for a spouse, parent, grandparent, great grandparent, step-parent, aunt, uncle, or Eligible Child age 13 or over, it may be provided outside your home only if the dependent spends at least 8 hours each day in your home. If care is provided outside of your home and the person or facility (providing the care) cares for more than six individuals, expenses will be eligible for reimbursement only if the person or facility complies with all applicable laws and regulations of any state or unit of local government. No payment will be made for dependent care provided by your spouse, Eligible Child, or other person for whom you or your spouse are entitled to take a dependent deduction on your federal income tax return.

6.3 Household Services. Expenses for household services may be reimbursed from your Dependent Care Account only if they are paid for the performance in and about your home of ordinary and usual services necessary to the maintenance of your household. The expenses must be attributable in part to the care of a dependent described in Section 6.1 above. As an example, amounts paid for the services of a domestic maid or cook may be reimbursed from your Dependent Care Account if a part of those services are provided to a dependent listed in Section 6.1. Expenses will not be reimbursed for the services of a chauffeur, bartender, or gardener. In addition, no payment will be made for household services provided by your spouse, Eligible Child, or other person for whom you or your spouse are entitled to take a dependent deduction on your federal income tax return.

6.4 Divorced or Separated Parents. Special rules apply in the case of dependent care or household services for an Eligible Child of parents who are divorced, legally separated, or separated under a written separation agreement. For such a child, expenses for dependent care and household services may be reimbursed from your Dependent Care Account only if the eligible child:

(a) is under age 13 (or, solely for the 2020 Plan Year (including any carryover amounts under Section 4.14), under age 14) or is physically or mentally incapable of caring for himself or herself,

(b) receives over half of his or her support during the year from his or her parents,

(c) is in the custody of one or both of his or her parents for more than half of the year, and

(d) is in your custody for a longer period during the year than in the custody of his other parent.

6.5 Alternative Tax Credit. In some circumstances it may be to your advantage *not* to contribute to your Dependent Care Account. That is because the Tax Code includes a dependent care “tax credit” which is an alternative to the dependent care benefits under this Plan. That alternative credit is described in Appendix C. Although the tax credit is an alternative – you cannot use both this Plan and the tax credit for the same dollar spent on dependent care – it is possible to use this Plan for a portion of your dependent care expenses and the tax credit for another portion. Use of this Plan does, however, reduce the amount of dependent care expenses for which you may claim the tax credit. You should review in detail the discussion found in Appendix C.

6.6 Special Nondiscrimination Rule. The Tax Code limits the extent to which Highly Compensated Employees may receive greater dependent care benefits than other employees. In addition, the average amount that *non*-Highly Compensated Employees receive in dependent care benefits for a year must be at least 55% of the average amount that Highly Compensated Employees receive. In making this computation, the Employer may disregard Employees earning less than \$25,000 per year. In the event the benefits to be received by Highly Compensated Employees would exceed the limitation just described, the Employer will require Highly Compensated Employees to reduce their contributions to their Dependent Care Accounts.

6.7 Debit and Credit (Stored Value) Cards. Subject to Section 2.1 and the following terms, you may, subject to any procedures established by the TPA, use a Card, as defined in Section 5.2(g), provided by the TPA, to receive reimbursements from your Dependent Care Account.

(a) Card Issuance. A Card will be issued when you first begin participating in the Dependent Care Account, and then reissued for each Plan Year that you participate. The Card will be automatically cancelled upon your death or termination of participation, or if you have a change in status that results in your withdrawal from the Dependent Care Account.

(b) Card Use. The Card may be used only for a Covered Dependent Care Expense. Such an expense may not be reimbursed before the expenses are incurred. If payment for such expenses is required before the dependent care or household services are provided, the expenses cannot be paid through the use of the Card.

(c) Maximum Dollar Amount Available. The dollar amount of coverage available on the Card will be the then-current balance of your Dependent Care Account.

(d) Substantiation. Each Card transaction will be subject to substantiation by the TPA, including, but not limited to, the following:

(1) At the beginning of the Plan Year or upon enrollment in your Dependent Care Account, you must pay any preliminary Covered Dependent Care Expenses to the service provider and substantiate such expenses by submitting to the TPA a receipt from the services provider describing the service, the date and the amount for the service provided; and

(2) After the TPA receives the substantiation (but not before the date the dependent care or household services are provided), the TPA will make available through the Card an amount equal to the lesser of:

(A) The previously incurred and substantiated Covered Dependent Care Expenses; or

(B) Your total benefit dollars contributed to date to your Dependent Care Account.

(3) The Card may be used to pay for subsequently incurred Covered Dependent Care Expenses.

(4) The amount available through the Card may be increased in the amount of any additional Covered Dependent Care Expenses only after the additional expenses have been incurred.

The TPA will also follow the requirements set forth in Notice 2006-69. All reimbursements will be conditional pending confirmation and substantiation.

(e) Correction. If a Card payment is later determined by the TPA to not qualify as a reimbursement for Covered Dependent Care Expenses, you will be required to repay the improper amount.

ARTICLE VII

EXCLUSIONS

Despite other provisions of this Plan to the contrary, no payment shall be made for any expense you incur:

- (a) For which you have received or are entitled to receive compensation under any Workers' Compensation or occupational disease law;
- (b) For a service that is provided by or paid for by any government agency;
- (c) Because of war or any act of war;
- (d) While engaged in service with the armed forces of any nation or state;
- (e) As a result of having engaged in a felony;
- (f) That you are not required to pay; or
- (g) While you are not covered under this Plan; for this purpose, an expense is incurred at the time the service or supply is actually provided.

ARTICLE VIII

ADMINISTRATION OF PLAN

The administration of the Plan is the responsibility of the Employer. The Employer has the power to carry out the Plan's provisions and to resolve any dispute or conflicts that arise under it. For a more detailed explanation of the Plan's administration, see Appendix D.

ARTICLE IX

GENERAL PROVISIONS

9.1 Any Questions? If you have any questions or need additional information about this Plan, you may contact Business Services, in writing or by telephone. The address and telephone number for the Business Services office is:

301 NE Tudor Rd
Lee's Summit, Missouri 64086
(816) 986-1000

9.2 Governing Law. The Plan is established in the State of Missouri. To the extent federal law does not apply, any questions arising under the Plan will be determined under the laws of the State of Missouri.

9.3 Interpretation. The Employer has the authority to construe the Plan and to determine all questions that arise under it. The Employer's interpretations are binding on you and your beneficiaries.

9.4 Alienation. No benefits under this Plan may be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for your debts or obligations. If a person who is entitled to receive a payment under the Plan is, in the Employer's opinion, incapable of giving a valid receipt for the payment and if no guardian has been appointed for that person, the Plan may make the payment to the person or persons who appears to have assumed the obligations of caring for the person on whose behalf the payment is made.

9.5 Legal Status of Plan. The Employer intends for this Plan, including all of its terms, to be legally enforceable by you. The Plan will be maintained for the exclusive benefit of employees.

9.6 Termination and Amendment. The Employer has the authority to terminate this Plan at any time or to amend and modify it from time to time as it deems proper. Any amendment or modification will be in writing and as formal as this Plan. If the Plan is terminated, the Employer will make payments to you from your accounts for covered expenses incurred during the remainder of the Plan Year, based on applications for payment filed after the Plan is terminated.

9.7 Funding Information. This Plan is funded through salary reductions made by Eligible Employees and contributions made by the Employer. Amounts contributed to the bookkeeping accounts established under Section 4.1 are held as part of the Employer's general assets until paid as premiums to the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan, or to you as requests for reimbursement of covered expenses are approved. Amounts contributed to a Health Savings Account, under Section 4.2, are held by the Plan's HSA provider.

9.8 Plan Information. The Plan is a "cafeteria plan" under Section 125 of the Tax Code. Plan records are maintained on a calendar year basis. The Employer's tax identification number is 44-6004933 and the Plan's number is 501. The number for the separate Dependent Care

Assistance Plan set forth in Article VI is 502. Its records are also maintained on a calendar year basis.

9.9 Agent for Service of Process. The Employer is the agent for service of process for the plan. Service of legal process may be made at the Stansberry Leadership Center, located at 301 NE Tudor Road, Lee's Summit, MO 64086.

9.10 Gender and Number. In the construction of this Plan, the masculine shall include the feminine and the singular the plural in all cases where those meanings would be appropriate.

9.11 Plan Not in Place of Workers' Compensation. This Plan is not in place of and does not affect any requirement for coverage by Workers' Compensation Insurance.

9.12 Privacy. The Plan will disclose to the Employer protected health information that is created or received under the General or Limited Medical Reimbursement Account portion of this Plan only to the extent permitted by the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations (the "Privacy Rule"). These procedures are described in Appendix E.

9.13 Effective Date. The changes made by this Restatement of the Plan are effective as of April 15, 2021. The Plan was originally effective as of October 1, 1987.

ARTICLE X

DEFINITIONS

10.1 Business Services means the Employer's Business Services Department.

10.2 Cancer Plan means the plan providing cancer insurance benefits, as sponsored by the Missouri State Teachers Association.

10.3 Dental Plan means any plan providing dental benefits that is sponsored by the Employer.

10.4 Dependent means any person who is (a) an Eligible Child, or (b) the spouse (unless legally separated) of an Eligible Employee or (c) exclusively for purposes of determining whether an expense is a Covered Medical Expense, an Eligible Parent.

10.5 Eligible Child means any person:

(a) Who is the natural, adopted, foster, or step-child of an Eligible Employee, or the descendant of such a child; and

(b) Who either:

(1) will be no older than age twenty-six (26) by the end of the calendar year; or

(2) will be over the age of twenty-six (26) but incapable of self-care because of a handicap and reliant on the Eligible Employee for support;

provided, however, that with respect to a Premium Account, such person shall be an "Eligible Child" only if he or she is eligible for coverage as the Eligible Employee's dependent under the Employer-sponsored plan to which such premium is paid.

10.6 Eligible Employee means any person who is a regularly scheduled full-time or part-time employee of the Employer who receives compensation included in a contract or compensation summary with the Employer.

10.7 Eligible Parent means any person who:

(a) Is the father or mother of an Eligible Employee;

(b) Has the same principal place of abode as the Eligible Employee for more than half of the calendar year;

(c) Does not provide more than half of his or her own support; and

(d) Is not, for federal tax purposes, the "qualifying child" of another taxpayer.

The rules under this Section 10.7 will be interpreted and applied consistently with the provisions set forth in Code Section 152. Notwithstanding any provision above to the contrary, a parent will not be considered an Eligible Parent if the parent is not a Dependent, as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

10.8 Employer means Lee's Summit R-7 School District.

10.9 HRA Plan means the Lee's Summit R-7 School District Health Reimbursement Arrangement Plan.

10.10 Highly Compensated Employee means an Eligible Employee who is a "highly compensated employee," within the meaning of Section 414(q) of the Tax Code.

10.11 HSA-Eligible Individual means an individual who is eligible to contribute to a Health Savings Account under Section 223 of the Code, who has elected qualifying High Deductible Health Plan coverage offered by the Employer, and who is not, while covered under a Qualified High Deductible Health Plan, covered under any other health plan which is not a Qualified High Deductible Health Plan.

10.12 Life Insurance Plan means any plan providing life insurance benefits that is sponsored by the Employer.

10.13 Medical Plan means any plan providing medical benefits that is sponsored by the Employer.

10.14 Plan means the Lee's Summit R-7 School District Cafeteria Plan, as herein set forth and as from time to time amended.

10.15 Plan Year means the period from January 1 to December 31.

10.16 Qualified High Deductible Health Plan means a health plan offered by the Employer that has an annual deductible which is not less than \$1,400 for single coverage (or \$2,800 for family coverage) and has an out-of-pocket maximum which is no more than \$7,000 for single coverage (or \$14,000 for family coverage), as those 2021 amounts are adjusted from time to time, and that otherwise satisfies the requirements of Section 223(c)(2) of the Code.

10.17 Tax Code means the Internal Revenue Code of 1986, as amended.

10.18 TPA means the third-party administrator designated by Business Services to assist with the day-to-day administration of the Plan.

10.19 Vision Plan means any plan providing vision benefits that is sponsored by the Employer.

10.20 You means any person who is covered under the Plan as an Eligible Employee.

IN WITNESS WHEREOF, Lee's Summit R-7 School District, by action of its duly-authorized representative, hereby adopts this restatement of the Lee's Summit R-7 School District Cafeteria Plan on this _____ day of _____, 2021, the same to be effective as of April 15, 2021.

Lee's Summit R-7 School District

By: _____

Its: _____

APPENDIX A

CONTINUATION OF COVERAGE UNDER COBRA

1. COBRA Qualifying Events. If you lose coverage under the General or Limited Medical Reimbursement Account portion of the Plan as a result of one of the following six events, and you have an unused balance in your General or Limited Medical Reimbursement Account, you (or your Dependents) may elect to continue that coverage, in accordance with the provisions of COBRA. These six “COBRA qualifying events” are as follows:

- (a) your death;
- (b) your termination of employment (other than for gross misconduct);
- (c) your reduction in work hours below the minimum needed to maintain eligibility under the Plan;
- (d) your entitlement to Medicare benefits;
- (e) your divorce or legal separation; or
- (f) your child ceasing to be a Dependent under the terms of the Plan.

It is the obligation of you or your Dependent to notify Business Services within 60 days of any divorce, legal separation, or child’s ceasing to be a Dependent under the Plan. If such timely notice is not received, the provisions of this Appendix A will not apply with respect to that event.

2. Maximum Coverage Period. If coverage is terminated, you or your Dependents may continue coverage through the end of the Plan Year in which the qualifying event occurs.

3. Cost and Coverage. The monthly charge for COBRA coverage will be equal to the amounts previously taken from your pay (plus an additional 2% of that amount, as an administrative fee); provided, however, that if you elect to continue coverage while you are on a leave of absence authorized under the Uniformed Services Employment and Reemployment Rights Act, there will be no administrative fee for the first 30 days of continued coverage. The COBRA coverage to which you and your Dependents are entitled will be the same as that provided to active Employees and their Dependents.

4. Electing COBRA Coverage. After Business Services is notified of a qualifying event, you will be sent a notice and an election form. If you wish to elect COBRA coverage, you must complete the election form and return it within 60 days from the later of the date it is sent or the date your coverage would otherwise terminate.

If you elect continued coverage, you must make payment for the period from the date coverage would otherwise terminate. Payment for this period must be made within a 45-day grace period after the date of the election. Subsequent payments must be made by the first day of each month for which coverage is to be provided – subject to a 30-day grace period.

5. Termination of COBRA Coverage. COBRA coverage is subject to automatic termination upon the occurrence of either of the following events:

(a) if a required payment is not made before the end of a grace period described in Section 4, above; or

(b) if the Employer ceases to maintain any group health plan on behalf of any active employees.

APPENDIX B

CONTINUATION OF COVERAGE UNDER THE FMLA

1. Continuation of Coverage. If you take a period of leave authorized by the Family and Medical Leave Act (“FMLA Leave”), you may continue coverage for yourself and your Dependents under the General or Limited Medical Reimbursement Account portion of the Plan during your period of FMLA Leave. You would do so by making the same contribution you would have made had you not taken FMLA Leave, but had instead continued your active employment and your participation in the Plan.

2. Timing of Payment for Coverage.

(a) Paid FMLA Leave. If you are on a period of FMLA Leave that is, at either your or your Employer’s election, paid leave substituted for FMLA Leave, your contributions for coverage will be made in the same manner that they would have been made had you not taken FMLA Leave (but had instead continued your employment and your participation in this Plan). Because active Employees make their contributions through salary reduction, your contributions during your paid leave would be made through salary reduction.

(b) Unpaid FMLA Leave. If your FMLA Leave is unpaid, you must make your contributions no later than the time they would have been made had you not taken FMLA Leave (but had instead continued your employment and your participation in this Plan).

(c) Termination of Coverage. If you are entitled to a period of FMLA Leave, you may elect not to continue coverage under this Plan during your leave. In that case, your coverage would terminate on the last day of the month for which you paid advance contributions. However, if you elect to continue coverage during a period of FMLA Leave, your coverage will continue until the earliest of:

- (1) The date you fail to return to work for your Employer after your period of FMLA Leave, and after your employment is thereby terminated;
- (2) The date you exhaust your entire FMLA Leave;
- (3) The thirtieth day following the date your contribution was due and unpaid (if that contribution remains unpaid on the thirtieth day); or
- (4) The date the Plan terminates.

(d) Restoration of Coverage. If you are on FMLA Leave and do not continue your coverage under this Plan (whether due to your failure to pay the required contributions or your election not to continue coverage during your period of leave), your coverage under the Plan will be reinstated upon your return from FMLA Leave. You will be entitled to receive the same coverage you had prior to your commencement of FMLA Leave.

(e) Special Rules for Key Employees.

(1) Key Employee. Special rules apply to key employees. For this purpose, a “key employee” is a salaried employee who is among the highest paid 10 percent of all employees employed by your Employer within 75 miles of one of your Employer’s worksites, and who is FMLA-eligible (who, for example, meets the minimum hour requirements, and works for a large enough facility, to be covered under the FMLA). Determinations of whether an employee is a key employee will be made under certain technical rules set forth in government regulations, found at 29 C.F.R. Section 825.217.

(2) Continuation of Coverage. If you are a key employee, special rules will apply. In that event, if you are entitled to FMLA Leave, and your Employer properly notifies you that it does not intend to restore you to your job at the end of your leave because doing so would cause substantial and grievous economic injury to your Employer’s operations, and if you nevertheless do not, within a reasonable time after receiving that notice, terminate your FMLA Leave and return to work for your Employer, your coverage (and that of your Dependents) will continue until the earliest of:

(A) The date you give notice to your Employer that you no longer wish to return to work;

(B) The date your Employer denies your reinstatement to employment at the end of your FMLA Leave;

(C) The thirtieth day following the date your contribution was due and unpaid (if that contribution remains unpaid on the thirtieth day);
or

(D) The date the Plan terminates.

3. Construction in Accordance With FMLA. The rules in this Appendix B will be interpreted and applied in a manner consistent with the provisions of the Family and Medical Leave Act and regulations the government issues under that Act.

APPENDIX C

TAX BENEFITS AVAILABLE FOR DEPENDENT CARE EXPENSES

Many people find it necessary to pay for the care of their children or other dependents so that they can work outside of the home. If that is your situation, you may be eligible for certain tax benefits provided under the Internal Revenue Code (the “Tax Code”). This Appendix C describes two of those benefits, and then helps you judge which would be best suited to your own circumstances. (Note that this discussion – including the table shown on the following page – is based on the Tax Code provisions in effect as of January 1, 2021.⁴ If these provisions are modified, the comparison between these two tax benefits may change, as well.)

Your Two Options

The Tax Code helps to pay for dependent care expenses in two different ways. First, it may be possible to exclude from your taxable income a portion of the dependent care expenses you incur. Second, you may receive a credit against your taxes equal to a portion of such expenses. Although the exclusion and credit are calculated in entirely different ways, they are both subject to essentially the same eligibility requirements. Moreover, the dependent care expenses to which each applies are limited to the earned income of you or your spouse, whichever is smaller. These requirements and limitations are described in Article VI of the Plan. The remainder of this discussion will assume that you are eligible for at least a certain level of both such benefits.

Dependent Care Exclusion

You will note that the dependent care exclusion is described in Article VI of the Plan. The exclusion works like this. You elect to have the Employer withhold a portion of your salary each month and contribute that amount to a Dependent Care Account. Those amounts, up to a maximum of \$5,000 per year, may be used to pay for the expenses of dependent care – and are then excluded from the amount of compensation reported on your Form W-2. In other words, this would not be a deduction (which you would have to itemize on your income tax return), but would simply never be considered a part of your income.

Dependent Care Credit

The dependent care credit is entirely different from the exclusion described above. A credit is applied directly against the amount of taxes you would otherwise pay. You must use a two-step process to calculate the amount allowed as a dependent care credit. First, you should determine the amount of your dependent care expenses. This amount is subject to an upper limit of \$3,000 for one dependent, and \$6,000 for two or more dependents. Second, you should determine your adjusted gross income. Generally speaking, this is the amount of your income before deductions or exemptions are subtracted. Depending on your level of adjusted gross income, you may claim

⁴ Temporary increases in both the dependent care exclusion and the dependent care credit are in effect for 2021. Because of these temporary changes, some employees who previously would have been better off from a tax perspective contributing to a Dependent Care Account may be better off claiming the dependent care credit in 2021 or vice versa. Please consult a tax advisor.

a tax credit of from 20% to 35% of your dependent care expenses. The following table will tell you which percentage is applicable to your level of adjusted gross income.

<u>Your Adjusted Gross Income</u>	<u>Applicable Percentage</u>
\$ 0 - \$15,000	35%
15,001 - 17,000	34%
17,001 - 19,000	33%
19,001 - 21,000	32%
21,001 - 23,000	31%
23,001 - 25,000	30%
25,001 - 27,000	29%
27,001 - 29,000	28%
29,001 - 31,000	27%
31,001 - 33,000	26%
33,001 - 35,000	25%
35,001 - 37,000	24%
37,001 - 39,000	23%
39,001 - 41,000	22%
41,001 - 43,000	21%
43,001 and over	20%

Thus, the maximum dependent care credit permitted by law is 35% of \$6,000, or \$2,100.

Which Is Best for You?

Because the exclusion and credit are calculated in entirely different ways, you will probably obtain a larger dollar benefit from one than you would from the other. You will need to consider your particular tax circumstances to know whether the tax credit or exclusion is best for you.

When You Might Use Both

Although you may take advantage of only one tax benefit for each dollar of dependent care expenses, you may choose one option for a portion of your dependent care expenses, and the other option for the remainder. Any dollars you claim under the dependent care exclusion will, however, reduce on a dollar-for-dollar basis the \$3,000 and \$6,000 limitations for the dependent care credit.

Obtain Independent Advice

Determining whether the dependent care exclusion, the dependent care credit, or a combination of both, produces the greatest tax benefits will ultimately depend on a number of variables unique to each individual's situation, such as tax filing status (e.g., married, single, head of household), number of dependents, earned income, tax bracket, etc. Thus, you should obtain independent tax advice before deciding whether to elect to participate in the Plan's dependent care benefit, to claim the dependent care credit, or to do both.

Plan Ahead

Whether you obtain independent advice or not, you will need to estimate certain items before deciding whether to elect to participate in the Cafeteria Plan's dependent care assistance benefit. These include, for each tax year, your earned income, your spouse's earned income, your adjusted gross income, your taxable income, and your dependent care expenses. Using those estimates, you should be able to determine your likely tax bracket, the percentage of the dependent care tax credit you will be eligible to claim, and the maximum expenses you may consider in determining your eligibility for either benefit. Once you have made these determinations, you should calculate the dollar benefits you would obtain using either or both of the options described above.

APPENDIX D

ADMINISTRATION OF PLAN

1. Plan Administrator. The administration of the Plan shall be under the supervision of Business Services. It shall be a principal duty of Business Services to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. Business Services will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, Business Services' powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants, third-party administrators, and other persons as may be required to assist in administering the Plan;

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing; and

(f) To enter into any and all contracts and agreements for carrying out the terms of this Plan and for the administration of the Plan and to do all acts as it, in its discretion may deem necessary or advisable, and such contracts and agreements and acts shall be binding and conclusive on the parties hereto and on the employees concerned.

Notwithstanding the foregoing, any claim which arises under the Cancer Plan, Dental Plan, Life Insurance Plan, Medical Plan, or Vision Plan shall not be subject to review under this Plan, and Business Services' authority under this Appendix shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations. Nor shall any claim arising under a Health Savings Account be subject to review under this Plan, and the Plan Administrator's authority shall not extend to any matter as to which the Plan's HSA provider under a Health Savings Account is empowered to make determinations.

2. Reliance on Tables, etc. In administering the Plan, Business Services will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the Cancer Plan, Dental Plan, Life Insurance Plan,

Medical Plan, and Vision Plan, or by accountants, counsel or other experts employed or engaged by the Employer.

3. Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving in an administrative capacity with respect to the Plan against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

4. Appeals. Pursuant to Section 2.2, the TPA will decide each claim for reimbursement from a General Medical Reimbursement Account, Limited Medical Reimbursement Account, or Dependent Care Account. Acting in accordance with Section 2.3, Business Services will then decide any first-level appeal from the denial of such a claim. Finally, decisions by Business Services under this Plan may be appealed, in writing, to the Employer's Superintendent or his or her designee.

5. Expenses. The proper expenses of Business Services, including the compensation of its agents, will be paid by the Employer, except to the extent that such expenses are paid out of forfeited contributions under Section 4.8.

APPENDIX E

DISCLOSURE TO THE EMPLOYER OF PROTECTED HEALTH INFORMATION

1. Construction. The rules in this Appendix E will be interpreted and applied in a manner consistent with the Privacy Rule. These rules apply only to the General or Limited Medical Reimbursement Account portion of the Plan.

2. Definitions. As used in this Appendix, the following terms have the following meaning:

(a) Plan means the General or Limited Medical Reimbursement Account portion of this Plan.

(b) Protected Health Information (“PHI”) means individually identifiable health information relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual that is created or maintained as part of the Plan.

(c) Summary Health Information means information that summarizes claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided benefits under the Plan, and from which the names, addresses, cities, counties, dates, telephone and fax numbers, email addresses, and social security numbers and other identifying numbers have been deleted.

3. Disclosures to the Employer. The Plan may disclose PHI to the Employer for the following purposes:

(a) The Plan may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of making decisions regarding modifying, amending, or terminating the Plan.

(b) The Plan may disclose to the Employer information on whether an individual is participating in the Plan.

(c) The Plan may disclose PHI to an Employer to carry out plan administration functions that the Employer performs, consistent with the provisions of Section 4 of this Appendix.

4. Obligations of the Employer. The Plan will disclose PHI to the Employer under Paragraph 3(c) of this Appendix only upon receipt of a certification from the Employer that the Plan documents have been amended to incorporate the following provisions.

(a) The Employer agrees to:

(1) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(2) ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(3) not use or disclose PHI for employment-related actions and decisions, unless authorized by the individual to whom the PHI relates;

(4) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer, unless authorized by the individual to whom the PHI relates;

(5) report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) make PHI available to an individual in accordance with the Privacy Rule's access requirements;

(7) make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule;

(8) make available the information required to provide an accounting of disclosures;

(9) make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of HHS for the purposes of determining the Plan's compliance with the Privacy Rule;

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

(11) ensure that adequate separation between the Plan and the Employer is established, as set forth in Paragraph 4(b) of this Appendix.

(b) Access to and use and disclosure of PHI will be limited to only those employees in Business Services and agents of the Employer who have a need for the PHI in conjunction with their performance of plan administration functions for the Plan, including any employee who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

(c) If the persons described in Paragraph 4(b) of this Appendix do not comply with the conditions set forth in Paragraph 4(a) of this Appendix, the Employer will provide a mechanism for resolving issues of noncompliance, including appropriate disciplinary sanctions.