

LINCOLN INTERMEDIATE UNIT

**Section 125 Plan Document
and Summary Plan Description**



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This Plan Document is amended and restated effective as of January 1st (the "Effective Date") by Lincoln Intermediate Unit (the "Employer").

BENEFIT SUMMARY

Flexible Spending Account Eligible Expenses

The Plan provides benefits for the following Eligible Expenses:

- 1) Health Flexible Spending Account ("Health FSA") - All medical expenses eligible under Section 213(d) of the Internal Revenue Code (IRC).
Minimum Contribution: \$0.00
Maximum Contribution: IRS Maximum
- 2) Dependent Care Assistance Plan ("DCAP") - Certain dependent care expenses that you pay for eligible dependents that are necessary while you and your spouse, if married, are attending school on a full-time basis or working.
Minimum Contribution: \$0.00
Maximum Contribution: \$5,000.00

Pre-Tax Premium Contributions

Each of the following "Benefit Options" have pre-tax contributions or a cash opt-out option:

Medical and Prescription

Plan Year

The Plan Year is the 12-month period beginning on January 1st and ending on the following December 31st.

Effective Date

The employee's participation in the Plan will become effective as of the first of the month following date of hire, if all other eligibility requirements are met and the employee enrolls within 30 days after the date of hire.

Grace Period

Not available

Carryover of Unused Expenses in Health FSA

IRS set limit

Claim Submission Deadline

All claims for the prior Plan Year must be submitted within 90 days after the end of the Plan Year or within 90 days after termination of participation in the Plan.

Claims Administrator

The Claims Administrator for this Plan is:
Lincoln Benefit Trust
65 Billerbeck Street
New Oxford, PA 17350

INTRODUCTION

This Section 125 Plan allows for pre-tax premium contributions to the Benefit Options shown in the Benefit Summary, health flexible spending account ("Health FSA") contributions and dependent care assistance plan ("DCAP") contributions.

The provisions of the Plan are subject to amendment due to changes in the laws or requirements of the Internal Revenue Service. The Employer may also amend or terminate this Plan. If the provisions of the Plan change, the Employer will notify Eligible Employees.

Purpose of the Plan

The purpose of this Plan is to allow eligible employees of the Employer to choose to use regular compensation, before taxes are deducted, to pay for health and dependent care expenses and to enroll in different types of benefits based on their own particular goals, desires and needs.

The Employer intends for this Plan to qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (the "Code") and that the benefits that an Employee elects to receive under the Plan be excluded from the Employee's income under Section 125(a) and other applicable sections of the Code. The Health FSA portion of the Plan is intended to qualify as a "self-insured medical reimbursement plan" under Code §105, and the Eligible Health FSA Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating employees' gross income under Code Section 105(b). The DCAP is intended to qualify as a "dependent care assistance plan" under Code Section 129, and the Dependent Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating employees' gross income under Code Section 129(a).

Benefits Available under the Plan

The plan includes a Health FSA and a DCAP. The Health FSA allows participating employees to pay for eligible health care expenses on a pre-tax basis. The DCAP permits an employee to pay for his or her qualifying Dependent Care Expenses with pre-tax dollars.

In addition to the Health FSA and DCAP, the Cafeteria Plan allows the employee to make pre-tax contributions to certain benefit options in which the employee may elect to participate.

Employees who are eligible to participate in the Plan

All employees are eligible to participate in this Plan, except for those employees shown below. In addition, only those employees who are eligible to participate in the medical benefit options are eligible to participate in the Health FSA.

The following employees are not eligible to participate in this Plan:

- Part-time employees working less than 25 hours per week

Enrolling in the Plan

To enroll in this Plan, eligible employees must complete an enrollment form within the time period required by the Employer or during an open enrollment period.

On the enrollment form, employees must indicate the amount, if any that they want to contribute to the Health FSA and/or the DCAP for the remainder of the Plan Year (if a new employee) or for the upcoming plan year. The amount that an employee elects to contribute to a Health FSA and/or DCAP will be deducted from the employee's paycheck in equal installments on a pre-tax basis. On another enrollment form, the employee will enroll in the Benefit Options and elect to contribute to those options on a pre-tax basis.

Every year participating employees will be asked to complete one or more new enrollment forms in order to confirm or change the amount that the employees contributes pre-tax to the Health FSA and/or DCAP and to elect other benefits that are offered on a pre-tax basis. Eligible employees who are not participating will also be given an opportunity each year to enroll in the Plan. If an employee does not submit a new Health FSA and/or DCAP enrollment form during any open enrollment period, participation in this Plan will end.

Effective Date of Coverage

Coverage will become effective as of the first payroll period following the date that the employee meets all of the eligibility requirements and has completed an enrollment form, through which the employee elects to participate in at least one benefit that is available under the Plan.

Changes to Elections and Enrolling before the next Open Enrollment Period

Other than during an open enrollment period, eligible employees can only enroll or make changes to the amount that they are contributing if they experience a qualifying life event.

The following are events that will allow participating employees to make an election change and, in some cases, will allow eligible employees who are not participating to enroll in the Plan:

- (a) *Change in Status*. An Eligible Employee may change his or her election under, or elect to participate in, the Plan due to a Change in Status, but only if the election change or election is on account of and corresponds with the Change in Status (referred to as the "general consistency requirement"). "Changes in Status" include changes in marital status, changes in the number of Dependents or the eligibility of Dependents, or changes in employment status (such as beginning or ending employment, strike, beginning or ending a leave of absence, changed in hours worked that impact eligibility, changes in another employer's plan covering an eligible employee, spouse or dependent.
 - (1) Election changes may be made to reduce Health FSA coverage during a period of coverage or to cancel Health FSA coverage completely due to a Change in Status. Such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. The Employer, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy specific consistency requirements in order for a participating employee to be able to alter his/her election based on the Change in Status.
 - (2) With respect to the DCAP Benefits, a participating employee may change or terminate his or her election upon a Change in Status if (a) such change or termination is made 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 eligibility of Dependent Care Expenses for tax exclusion.
- (b) *Special Enrollment (applies to Benefit Options and Health FSA Benefits, but not DCAP Benefits)*. An event occurs that triggers one of the HIPAA Special Enrollment Rights including the employee or his or her Spouse or Dependent previously declining coverage and a new dependent is acquired as a result of marriage, birth, adoption, or placement for adoption; or because he or she had coverage and eligibility for such coverage is subsequently lost because it was exhausted (COBRA) or terminated due to loss of eligibility, loss of employer contributions or termination of the plan.
- (c) *Certain Judgments, Decrees and Orders (Applies to Benefit Options and Health FSA Benefits, Not to DCAP Benefits)*. If a Qualified Medical Child Support Order (QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for an eligible employee's Dependent, an eligible employee may (1) change his or her election or elect to provide for the Dependent child (provided that the QMCSO requires the eligible employee to provide coverage); or (2) revoke coverage for the Dependent child if the QMCSO requires that another individual (including the participating employee's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.
- (d) *Medicare and Medicaid (Applies to Benefit Options and Health FSA Benefits as limited below, but not to DCAP Benefits)*. If a participating employee or his or her Spouse or Dependent becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the participating employee may prospectively revoke. Such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a participating employee or his or her Dependent who has been entitled to Medicare or Medicaid loses eligibility for

coverage, the Participating employee may elect to commence coverage in a Benefit Option or commence or increase the participating employee's Health FSA coverage.

- (e) Change in Cost (Applies to the Benefit Options only). If there is a significant change in cost (whether an increase or decrease) in one of the Benefit Options, participating employees can change their elective contributions to be increased or decreased. The Employer, in its sole discretion and on a uniform and consistent basis will determine whether the cost increase or decrease is significant or insignificant. For an insignificant increase or decrease, the change in election will be made automatically on a prospective basis.
- (f) Significant Curtailment of Coverage (Applies to the Benefit Options only). If there is a significant curtailment of coverage or an addition or significant improvement in a Benefit Option. The Employer in its sole discretion and applied on a consistent basis will determine whether there has been a significant curtailment (with or without loss of coverage) or an addition or significant improvement in a Benefit Option that entitles a participating employee to make a corresponding election change. In the case of curtailment that results in a loss of coverage, the Employer may permit the participating employee to withdraw from the Plan.
- (g) Benefit Plan Change in Coverage. There is a change made under another employer plan and the other plan allows an election change or the other employer plan has a different period of coverage.
- (h) Loss of Medicaid or SCHIP Coverage (Applies to the Benefit Options only). The participating employee, Spouse or a Dependent loses coverage under a Medicaid Plan under Title XIX of the Social Security Act or State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act;
- (i) Premium Assistance (Applies to the Benefit Options only). The participating employee, Spouse or a Dependent is determined to be eligible for group health plan premium assistance under Medicaid or SCHIP plan.
- (j) DCAP Change in Cost. A participating employee may make a prospective election change that is on account of and corresponds with a change in the cost of the participating employee's dependent care service provider who is not, as determined by the Plan Administrator, the participating employee's "relative."
- (k) DCAP Coverage Changes. A participating employee may make a prospective election change that is on account of and corresponds with a change by the participating employee in the dependent care service provider. For example:
 - (1) if the participating employee terminates one dependent care service provider and hires a new dependent care service provider, the participating employee may change coverage to reflect the cost of the new service provider; and
 - (2) if the participating employee terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participating employee may cancel coverage.

Changes to participation and/or to contribution amounts during the plan year must be made on account of and consistent with the event and must be made within 60 days of the event (or within 60 days if the event is loss of Medicaid or CHIP or eligibility for premium assistance). Except for changes to add dependents due to birth or adoption of a child, all changes will become effective after the submission of a change form requesting the change in coverage. Changes due to birth or adoption will be effective retroactively to the date of birth or adoption if the change is submitted within the required period.

Changes to reduce Health FSA coverage or to cancel the coverage are not permitted if the change would cause the total contributions for the year to go below the amount already reimbursed.

Changes to elections under the DCAP Plan are permitted if the change or termination is made on account of and corresponds with a change that affects eligibility for coverage under another employer's plan; or the change affects eligibility of the dependent care expenses for tax exclusion.

PRE-TAX PREMIUM CONTRIBUTIONS

Benefit Options

The specific benefits, types and amounts of coverage, requirements for participation, and other terms and conditions of the coverage provided under the Benefit Options are fully explained in the plan documents for each of these Plans. A list of the Benefit Options that are subject to this Plan is shown in the Benefit Summary.

Funding the benefits available under the Benefit Options

All self-funded Benefit Options are provided in accordance with the plan document for those plans. All claims to receive benefits and issues of coverage will be subject to and governed by the terms and conditions of the applicable plan documents. This Plan allows eligible employees to elect to participate in any available Benefit Options by paying their share of the premium using pre-tax contributions.

Contributions to Benefit Options

The amount that employees will be required to contribute to the cost of the Benefit Options will be communicated to eligible employees when first eligible and each year at open enrollment.

Coverage of Spouses and Children

Legally married spouses ("Spouses") and children ("Dependents") of a participating employee is eligible to participate in any of the Benefit Options that include coverage of Spouses and/or Dependents. Eligibility for participation in the Benefit Options that include this coverage is described in the plan documents for those plans.

Spouse Surcharge and Eligibility for Medical/Prescription Plan – Professional and Administrative Staff

A spousal surcharge will be charged to employees who elect coverage for their spouse under this Plan. (Any administrative employee hired prior to August 1, 2016 and any professional employee hired prior to July 1, 2016, whose enrolled spouse is not employed, is exempt from this surcharge.) The definition for "employment" for this policy is any spouse with spousal income reported for taxable purposes on the following IRS forms: W-2 (earned income), 1099 (other income), Schedule C (Business Income), Schedule F (Farm Income), or Schedule E (Partnership Income). If the spouse is retired and only receiving retirement income, he/she will be excluded from this surcharge.

Qualified Medical Child Support Orders

An eligible Dependent under the Benefit Options may include a child for whom a participating employee is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or administrative judgment, decree or order that is typically issued as part of a divorce or as part of a state child support order proceeding and that requires Health Plan coverage for an "alternate recipient" (meaning either a child of a Participating employee or Employee or state or political subdivision acting on behalf of a child). The alternate recipient must be treated like any other Dependent.

Upon receipt of a child support order, the Employer will promptly send a written notice of receipt of the order to the participating employee and all alternate recipients named in the order and their legal representatives. If the Employer receives a National Medical Support Notice, it will review the content and, if all required information is provided, notify the state agency whether coverage for the child is available under the Plan and indicate the effective date of coverage (or any steps necessary to make the coverage effective, including copies of any forms that must be completed). The Employer will also send a description of the coverage and a copy of its QMCSO Procedures.

After sending the notice of receipt, the Employer has the ultimate authority to determine whether or not the order meets the requirements of a QMCSO. Within 40 days after the date of the order, the Employer will notify the participating employee and the alternate recipients that either the order is a valid QMCSO or that the order is not a valid QMCSO. If an order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order.

Coverage will become effective for the eligible child(ren) on the first day of the month following the later of (1) the date of the Employer notification to the alternate recipient that the notice is a valid QMCSO; or (2) the date the Employer receives any required enrollment forms; or the date specified in the QMCSO. If the Employee has not yet met the waiting period, coverage will not become effective until the end of the waiting period.

HEALTH FLEXIBLE SPENDING ACCOUNT

General Information

During enrollment, eligible employees specify how much they want to set aside from each paycheck up to the maximum annual amount shown on the Benefit Summary. The annual election must be no less than the minimum shown on the Benefit Summary. This amount is withheld from the Participating employee's pay in equal installments, but the total amount is available immediately.

When a participating employee has an eligible expense, the employee must submit a claim form to the Claims Administrator. The claim form must be submitted with an Explanation of Benefits from an insurance Employer or medical claims administrator. If the claim was not submitted to a health plan, the employee can submit a detailed receipt from the provider to the Claims Administrator.

If a paper claim is eligible for reimbursement and has been substantiated, the Claims Administrator will send the employee a check and subtract that amount from the Health FSA balance.

Maximum Contribution

The maximum contribution for the Health FSA is shown in the Benefit Summary. If both the employee and his/her spouse are employees of the Employer both can contribute up to the maximum shown.

Minimum Contribution

In order to participate in the Health FSA, the employee must contribute at least the amount shown on the Benefit Summary during any Plan Year.

Uniform Coverage Rule

The annual election made by a participating employee for the Plan Year, along with any contribution made by the Employer, will be available as of the date that participation in the Plan begins regardless of the funds that have actually been contributed through payroll deduction.

Funds not used for Reimbursing Expenses

The IRS requires that employees forfeit any unclaimed money in a Health FSA (if any) at the end of each Plan Year or after termination of participation in the Plan, except that employees are permitted to carryover for use during the next Plan Year the lesser of the amount remaining in the Health FSA after the Claims Submission Deadline or the carryover limit set by the IRS for that plan year.

Use of Forfeitures

All forfeitures under this Plan shall be used as follows:

- First, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participating employees in excess of the Contributions paid by such Participating employees through Salary Reductions;
- Second, to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
- Third, to provide increased benefits or compensation to participating employees in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations. In addition, any

Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the period of coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Limitations that apply to Highly Compensated Employees

The Employer may be required to limit the amount of contributions by Key Employees, as defined by the IRC, so that the total benefits to Key Employees do not exceed 25% of the benefits provided to all employees. Contributions by Highly Compensated Employees may be limited to ensure that the plan does not discriminate against the non-Highly Compensated Employees. The Employer will notify any employee to whom this limitation applies.

Eligible Health FSA Expenses

To be eligible for reimbursement, health care expenses must meet the statutory requirements of Internal Revenue Code §213(d). However, when paying claims, neither the Employer nor the Claims Administrator is providing tax advice. The employee is responsible for making sure that all expenses submitted for reimbursement are eligible.

Here are some of the requirements for expenses to be considered eligible:

- The expense must be incurred after the date of election and the effective date of coverage, and during the Plan Year to which the election applies. An expense is incurred when the care is provided rather than when the employee is billed or when the employee pays for the service. Any expenses incurred after participation in the Plan ends are not eligible, though employees will have until the Claims Submission Deadline shown in the Benefit Summary to submit any expenses incurred during the period of participation. See the section on COBRA continuation for a discussion of extended coverage.
- The expense must be primarily for medical care.
- The health care expense must not be eligible for reimbursement under any other health care plan. NOTE: If the employee, spouse or dependent receives reimbursement under this Plan for an expense that is later reimbursed by another plan, the employee is required to send back to the Employer or Claims Administrator any funds that were improperly reimbursed.
- If the employee or spouse is enrolled in a High Deductible Health Plan with an HSA, eligible expenses include only dental and vision expenses until the deductible under the health plan has been satisfied. After the health plan deductible has been met, coinsurance expenses will be eligible for reimbursement. No other medical expenses will be eligible for reimbursement.

Some expenses currently considered reimbursable by the IRS include:

- Prescription drugs, vaccines, doctor prescribed birth control pills;
- Services performed by medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, dermatologists, psychologists and physical therapists;
- Medical treatment including alcohol and substance abuse, hospital services, lab fees, legal abortion, organ transplants, in-vitro fertilization, x-rays for medical reasons, sterilization, vasectomy, insulin treatment and well-baby care;
- Medical equipment such as hearing aids, eyeglasses, contact lenses, braces, crutches, artificial limb, abdominal supports, back supports and orthopedic shoes; and
- Ambulance service, transportation costs essential to medical care;
- Over-the-counter drugs.

Items not eligible for reimbursement under this Plan include but are not limited to:

- Expenses reimbursed through any other insurance plan;
- Health care premiums;
- Treatments or drugs for cosmetic purposes.

Dependents who expenses are Eligible for Reimbursement

The health care expenses of the following individuals are eligible for reimbursement under the Health FSA:

- An eligible employee of the Employer who participates in the Plan
- A participating employee's spouse; and/or

- Any child (as defined in Internal Revenue Code §152(f)(1)) of the Participating employee who as of the end of the taxable year has not attained age 27 and any other individual who is a dependent as defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof and related IRS publications.

DEPENDENT CARE ASSISTANCE PLAN

General Information

During enrollment, eligible employees specify how they want to set aside from his/her pay to be used for dependent care expenses. This amount is withheld from the employee pay in equal installments.

When a participating employee has an eligible expense, the employee will submit a claim form to the Claims Administrator, along with paperwork to substantiate the expense. This paperwork must include a statement from the service provider that includes the dates of service, the dependent's name and name and address of the provider.

The Claims Administrator will send the employee a reimbursement check to the extent that the claim has been substantiated and funds are available. The amount of funds available will be based on how much has been withheld from the employee pay and how much has been previously reimbursed.

Maximum Contribution

The maximum contribution for the DCAP is shown in the Benefit Summary. If both the employee and his/her spouse are employees of the Employer both can contribute up to the maximum shown. If the employee is married and resides with his/her spouse, but they file a separate income tax return, then the maximum that the employee may elect is \$2,500 (or half of the maximum shown if less than \$5,000). This maximum includes any amount contributed by both the employee and spouse. Also, an annual contribution to a DCAP cannot exceed the employee's or spouse's earned income for the year.

Minimum Contribution

In order to participate in the DCAP, the employee must contribute at least the amount shown on the Benefit Summary during any Plan Year.

Eligible Dependent Care Expenses

Dependent Care Expenses mean employment-related expenses incurred on behalf of any dependent under federal tax law who meets the requirements to be a qualifying dependent as described in this Plan Document.

Dependent Care Expenses must also meet the following requirements:

- The expense must be incurred after the date of election to receive Dependent Care benefits and during the Plan Year including the Grace Period, if any, to which the election applies. A Dependent Care Expense is incurred when the service that gives rise to the expenses is provided, regardless of when the expense is billed or paid. A childcare expense is not incurred until the end of the period for which the employee has paid.
- The expense must have been incurred to enable the employee (and the employee spouse, if the employee is married) to be gainfully employed, which generally means working or looking for work. (Exception – if the employee spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care).
- The employee (or the employee and the employee's spouse together) are providing at least 50% of the cost of maintaining the employee household, and the expense is incurred when at least one member of the employee household is a qualifying dependent.
- The expense is incurred for the care of a qualifying dependent or for household services attributable in part to the care of a qualifying dependent.
- If the expense is incurred for services outside the employee household, they are incurred for the care of (1) a person under age 13 who is the employee dependent under federal tax law; or (2) the employee spouse or a person who is the employee dependent under federal tax law and who is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in the employee household. The employee must provide over 50% of the dependent's financial support.

- If the expense is incurred for services provided by a dependent care facility, the center complies with all applicable state and local laws and regulations and is licensed to care for more than 6 children at a time.
- The person who provided care was not the employee's spouse or a person for whom the employee is entitled to a personal exemption under Code § 151(c). If the employee's child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The care cannot be provided at a nursing home facility.
- The expense cannot be paid for services outside the employee's household at a camp where the dependent stays overnight.

The employee can get more information about what items are and are not eligible Dependent Care Expenses in IRS Publication 503.

Eligible Dependents whose Expenses can be Reimbursed

Each Dependent, considered a qualifying dependent, for which the employee incurs reimbursable expenses must be:

- A person under age 13 for whom the employee is entitled to claim a dependency exemption on the employee's federal income tax return (if the employee is a divorced parent, a child is the employee's Dependent if the employee has custody of the child, even if the employee is not entitled to claim the dependency exemption); or
- The employee's spouse or a person who is the employee's dependent under federal tax law (whether or not the employee is entitled to claim the dependency), but only if he or she is physically or mentally incapable of self-care.

FLEXIBLE SPENDING ACCOUNT CLAIMS AND APPEALS

Filing Claims

Employees can get a copy of the claim forms from the Employer or the Claims Administrator. Claims can be submitted until the Claims Submission Deadline shown in the Benefit Summary. Except at the end of the Plan Year (or corresponding Grace Period, if any), the minimum reimbursement amount is \$25. Claims less than \$25 should be submitted with other claims to total over \$25 in order to ensure timely reimbursement.

For the Health FSA, Participating employees should include a copy of the health plan Explanation of Benefits with the claim. If the employee did not submit the claim for reimbursement, the employee is permitted to submit a copy of a detailed bill or receipt. The employee will have access to the total amount that the employee elected for the Plan Year as soon as any eligible expenses are incurred.

For the DCAP, the employee must include written statements and/or bills from independent third parties stating that the dependent care expenses have been incurred, and the amount of such dependent care expenses, along with the employee claim form. The employee will be reimbursed for dependent care expenses only to the extent that the employee has the money available in the employee dependent care account.

Claims for both Accounts can be submitted up to the Claims Submission Deadline shown on the Benefit Summary. The employee must certify on the claim form that the employee expenses are eligible under the Plan and that they have not been reimbursed by another plan. If the claims are later reimbursed or paid by another plan, the employee is required to reimburse the Employer for these claims. Please send the overpayment back to the Claims Administrator shown on the Benefit Summary.

Timing of Claims Payment

All claims will be processed and paid (if eligible under the Plan) within 30 days of receipt of a completed reimbursement form. However, the Claims Administrator may request a 15-day extension for matters beyond its control.

Health FSA Claim Denial

If a claim is denied because it is incomplete, the Claims Administrator will provide the employee with a description of any additional material or information necessary and an explanation of why this material or information is necessary.

After receipt of all the information needed to review a claim, if any claim for benefits under the Plan is wholly or partially denied, the Claims Administrator will give notice in writing of the denial within 30 days after the claim is filed or 45 days if the Claims Administrator requests a 15-day extension for matters beyond control of the Plan. If the Claims Administrator requests additional information, the employee will have 45 days to provide that information.

The denial notice will include the following information:

- Information that will help the employee identify the claim that is being denied;
- The specific reason or reasons for the denial;
- Specific reference to the Plan provision, internal rule, guideline, protocol or similar criteria on which the denial is based;
- An explanation that a full and fair review by a claim review committee of the decision denying the claim may be requested within 180 days after the notice of denial has been received.

If the employee requests a review of the claim denial, the employee may review pertinent documents and submit issues and comments in writing that will assist us with reviewing the appeal. The decision of the Claims Administrator on review will be made promptly, but not later than 60 days after receipt of the request for review, unless special circumstances require an extension of time for processing. The decision on review will be made in writing and will include specific reasons for the denial, written in a manner that the employee can understand and will include references to the Plan provisions on which the denial is based. If the claim is denied the employee have to right to an additional internal appeal and, depending on the type of claim, an external review by an Independent Review Organization (IRO). The Claims Administrator will coordinate these appeals.

Claims and Appeals Procedure for the DCAP

The claims for the DCAP will be reviewed by the Claims Administrator and decided in a uniform and non-discriminatory manner. A participating employee may appeal any denial of a claim to the Claims Administrator within sixty (60) days of the original decision.

Taxability of Reimbursements

It is the employee's responsibility to make sure that expenses the employee submits for reimbursement are eligible under the IRS regulations. The employee is responsible for taxes and penalties associated with any ineligible expenses if the IRS audits the employee.

TERMINATION OF COVERAGE

Termination of Health FSA and DCAP Coverage

An employee will no longer participate in the Health FSA and/or DCAP when any of the following occurs:

- At the end of any Plan Year, if the Employee fails to submit an enrollment form to elect coverage during any open enrollment period;
- When the Plan terminates;
- As of the date the Employee is no longer eligible (because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility under the Health FSA may continue beyond that date for if the employee is eligible to and elect COBRA coverage for the Health FSA;
- As of the date the employee revokes an election to participate under a circumstance when such change is permitted;
- As of the date that the employee fails to make a required contribution; or
- As of the date the employee commits a fraud against the Plan.

Termination of Coverage under the Benefit Options

The terms of the Benefit Options are governed by the plan documents for those benefits. Pre-tax premium contributions to those benefits will terminate no later than the date that the coverage terminates.

Health FSA and DCAP Account Balances after Termination

If the employee loses coverage under the Plan due to termination of employment or loss of eligibility, the employee will lose any amount remaining in the employee's Health FSA and DCAP, except for any money that is reimbursed for a claim that is submitted within the Claims Submission Deadline, but which was incurred while the employee and/or spouse and dependents (depending on who incurs the claim) were still covered by the Plan. If the employee resumes employment with the Employer within 30 days, the employee's Plan elections will be automatically reinstated.

Continued Coverage during a Disability and/or Leave of Absence

For Health FSA coverage and Benefit Options subject to FMLA, if the employee is not working for a period of time, the employee's accounts and coverage under the Benefit Options will remain in force unless the employee chooses to terminate participation in the Plan. If the employee does not terminate participation, the employee will need to continue to pay the employee contributions, either on a post-tax basis or on a pre-tax basis prior to or after the leave.

If the employee takes a paid leave of absence, employee contributions will continue to be made to the plan through payroll deduction. If the employee takes an unpaid leave of absence, the employee may pay his or her share of the premium and all contributions in one of the following ways as determined by the Employer or any applicable employment policy:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pretax dollars, by prepaying such amounts with the employee's pre-leave compensation if any, including unused sick days and vacation days. Any election to prepay using pretax dollars is applicable only for the period beginning with the first day of the leave and ending on a date no later than the last day of the Plan Year. If a leave spans two Plan Years, the employee may not prepay his or her required contributions with pretax dollars for the portion of the leave that falls within the second (or subsequent) Plan Year; or
- under another arrangement agreed upon between the employee and the Employer (for example, the Employer may withhold "catch-up" amounts, on a pretax Salary Reduction basis, from the employee's compensation upon the employee's return from the leave).

If an employee's participation in any of the Benefit Options that are subject to the FMLA, the Health FSA and/or DCAP terminates while on leave (for example, for non-payment of required contributions), the employee is entitled to reinstate the benefits upon return from such leave on the same basis that the employee was participating in the Plan before the leave if the leave was subject to the FMLA or as otherwise required by the Employer's policies for non-FMLA leave and for benefits not subject to FMLA.

An employee whose Health FSA coverage stopped during the leave will be entitled to elect whether to be reinstated in the Health FSA (a) at the same coverage level as in effect before the leave (with increased contributions for the remaining period of coverage), or (b) at a coverage level that is reduced pro rata for the period of leave during which the employee did not pay premiums. If a participating employee elects a coverage level that is reduced pro rata for the period of leave, the amount withheld from compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA benefits will be equal to the amount withheld in each paycheck prior to the leave.

If a participating employee goes on a leave of absence that is not subject to the FMLA or for benefits that are not subject to the FMLA, the employee can continue coverage during the leave in accordance with the Employer's policies. If the Employer's policies do not address continuation of coverage during non-FMLA leaves or for benefits not subject to the FMLA, employees will be permitted to continue coverage during the leave for up to 12 weeks provided that contributions are made on a post-tax basis during the leave (or if the leave is paid, contributions will be deducted from pay).

CONTINUED COVERAGE AFTER TERMINATION**COBRA for the Health FSA after Coverage Terminates**

The employee may elect to continue the employee coverage under the Health FSA, if there is a positive balance in the Health FSA at the time of termination, only up until the end of the current Plan Year after the employee is no longer employed by the Employer or otherwise lose coverage because of a "qualifying event". The employee will need to follow the procedures set forth in the Notice that the employee will receive when participation ends. Coverage will continue only

if the employee makes direct, after-tax payments through the end of the Plan Year. There is no continuation of coverage available for the DCAP.

Qualifying events include termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of dependent. A Participating employee or dependent who is covered under the Plan must notify the Plan Administrator of any divorce, legal separation, or a child ceasing to be considered a Dependent under the Plan within 60 days after the event. This notice must be in writing and addressed to the Plan Administrator. In addition, if a second qualifying event occurs during COBRA continuation coverage or if the former employee becomes entitled to Medicare or dies during the COBRA coverage, the participating employee or Dependent must notify the Employer. Finally, a COBRA participating employee must notify the Employer before the start or end of any disability that is determined under the Social Security Act to be a covered disability.

Any notice described in the above paragraph must be provided in writing to the Employer within 60 days of the occurrence of the applicable event (except that if there is a change in the participating employee's disability status, notice must be given within 30 days). If the participating employee, spouse or dependent fails to provide notice within the required time period, he or she may no longer be eligible for COBRA continuation coverage. In this event, the Employer or its COBRA Administrator may send Notice of Unavailability of COBRA Coverage upon receipt of the late notice.

Additional information about COBRA rights are included in the general COBRA notice, which has been provided to the employee and the employee's spouse (if covered) at the time of enrollment in the Health Plan. The employee can contact the Employer for another copy.

COBRA Coverage for Benefit Options

Certain Benefit Options may also be eligible for COBRA continuation coverage. Additional information can be found in the plan documents for those benefits and in the general COBRA Notice.

PRIVACY AND SECURITY

Use of PHI

The Plan will use a participating employee's, spouse's or dependent's protected health information ("PHI"), in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), only to make required disclosures or for purposes related to treatment, payment for healthcare, and the healthcare operations of the Plan or to make any other disclosures that are required by law. However, if a participating employee, spouse or dependent requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

Obligations of Employer with respect to PHI

With respect to PHI, the Employer will:

- (a) Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
- (b) 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;
- (c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- (d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual that is the subject of the PHI;
- (e) Make PHI available to an individual in accordance with HIPAA's access requirements;
- (f) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (g) Make available upon request an accounting of disclosures;
- (h) Make available to the Secretary of the Department of Health and Human Services internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA;
- (i) Provide written notice or a substitute notice (if the last known contact address is insufficient) for each individual within

60 days following discovery of any breach of Unsecured PHI. The notice will include:

- (j) A brief description of what happened including the date of the breach and the date of discovery, if known;
- (k) A description of the types of unsecured PHI that were involved in the breach;
- (l) Any steps the individual should take to protect him/herself from potential harm resulting from the breach;
- (m) A brief description of what the Employer is doing to investigate the breach in accordance with HIPAA breach notification requirements;
- (n) Contact procedures for individuals to ask questions or learn additional information
- (o) If a breach of unsecured PHI involves more than 500 residents of a state, provide notice to local media outlets serving the state within 60 days of discovering the breach;
- (p) If a breach of unsecured PHI involves more than 500 covered persons, provide notice to the DHHS not later than 60 days after the end of the calendar year in which the breach occurred;
- (q) If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
- (r) Use DHHS approved methods to secure and destroy PHI.

With respect to Electronic PHI, the Employer will (if PHI is or has been stored on the Employer's computer system):

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- (b) Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent or business associate to whom the Plan Sponsor provides electronic PHI agrees to comply with the HIPAA Security Requirements and to provide notice to the Plan of any breach of unsecured PHI, once the breach is known to the agent or business associate or should reasonably have been known to the agent or business associate;
- (d) Report to the Plan any security incident of which the Employer becomes aware; and
- (e) Use methods to encrypt PHI that are approved by the Department of Health and Human Services.
- (f) Access to PHI

Only specified employees of the Employer may be given access to PHI, and they may use and disclose PHI only for plan administration functions (which includes both Payment and Health Care Operations) that the Employer performs for the Plan. If any of these persons do not comply with the HIPAA provisions of this Plan Document, the Employer will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

HIPAA Definitions

- (a) Breach means the unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by HIPAA privacy rules that compromises the security or privacy of the PHI.
- (b) DHHS means the federal Department of Health and Human Services.
- (c) Electronic PHI is health information about a plan participating employee that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.
- (d) Health Care Operations means activities of the Plan related to its health care functions, including quality assessment, case management, care coordination, reviewing competence of health care professionals, evaluating provider performance, health plan performance, cost management, resolution of grievances, or any other related activities.
- (e) Payment includes all activities regarding the provision of benefits under the Plan.
- (f) Protected Health Information or PHI shall mean any individually identifiable health information in electronic, oral or written form that pertains to the past, present or future mental or physical condition of an individual. Protected Health Information is limited to the information created or received by the Employer or its business associate on behalf of the Health FSA Plan. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.
- (g) Unsecured PHI means PHI that is not secured through the use of a technology or methodology described in regulations to the HITECH Act or otherwise approved by the Secretary of the DHHS.

OTHER INFORMATION

Amendment and Termination of the Plan

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax law may require that the Plan be amended accordingly.

Duties of the Plan Administrator

The Plan Administrator shall have the powers it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan. All determinations of the Plan Administrator with respect to the Plan shall be conclusive and binding on all persons. The Plan Administrator shall have the following discretionary authority:

1. to construe and interpret the Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under the Plan;
2. to prescribe procedures to be followed and the forms to be used by Employees and participating employees to make elections pursuant to the Plan;
3. to prepare and distribute information explaining the Plan and the benefits under the Plan in an appropriate manner;
4. to request and receive from all employees and participating employees information the Plan Administrator determines to be necessary for the proper administration of the Plan;
5. to receive, review and keep on file reports and information regarding the benefits covered by the Plan as the Plan Administrator determines to be necessary and proper;
6. to appoint and employ individuals or entities to assist in the administration of the Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
7. to sign documents for the purposes of administering the Plan, or to designate an individual or individuals to sign documents for the purposes of administering the Plan;
8. to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
9. to maintain the books of accounts, records, and other data in the manner necessary for proper administration of the Plan and to meet any applicable disclosure and reporting requirements.

Reliance on Participating employee, Tables, etc.

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

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an employee, the allocations made to the account of any participating employee, or the amount of benefits paid or to be paid to a participating employee, the Plan Administrator shall, to the extent administratively possible and otherwise permissible, make adjustment of the amounts as it will in its judgment accord to the Participating employee the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer.

No Employment Rights Conferred

Neither the Plan nor any action taken with respect to it will confer upon any person the right to be continued in the employment of the Employer.

Payments to Beneficiary

Any benefits otherwise payable to a participating employee following the date of death of such employee will be paid to

his/her spouse, or, if there is no surviving spouse, to his/her estate.

Inability to Locate Payee

If the Claims Administrator is unable to make payment to any participating employee or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of such employee or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of the employee or other person as shown on the records of the Employer), the payment and all subsequent payments otherwise due to such employee or other person will be forfeited seven (7) years after the date such payment first became due.

Non-alienation of Benefits

Neither the Health FSA nor the DCAP benefits will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so will be void. No such benefit shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. If any person entitled to benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge any Benefit under the Plan, or if any attempt is made to subject any such benefit to the debts, contracts, liabilities, engagements or torts of the person entitled to any such benefit, except as specifically provided in the Plan, then such benefit will cease and terminate in the discretion of the Plan Administrator, and he may hold or apply the same or any part thereof to the benefit of any dependent or beneficiary of such person, in such manner and proportion as he may deem proper.

Mental or Physical Incompetency

If the Plan Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, it may cause all payments thereafter becoming due to such person to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Claims Administrator, the Plan Administrator (if other than the Employer) and the Employer.

Requirement of Proper Forms

All communications in connection with the Plan made by a participating employee will become effective only when executed on forms provided by and filed with the Plan Administrator and/or the Claims Administrator.

Source of Payments

The Employer will be the sole source of Benefits under the Health FSA and DCAP. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Health FSA or DCAP to such Employee or beneficiary.

Compliance with Relevant Statutes

It is intended that the Plan meet all applicable requirements of the Internal Revenue Code (the "Code"). The Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of the Plan and the Code, the provisions of the Code shall be controlling, and any conflicting part, clause or provision of the Plan shall be superseded to the extent of the conflict.

Headings

The headings contained herein are for convenience of reference only, and will not be construed as defining or limiting the matter contained there under.

Applicable Laws

The provisions of the Plan will be construed, administered and enforced according to applicable federal law and the laws of the Commonwealth of Pennsylvania.

Severability

Should any part of the Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof will be given effect to the maximum extent possible.

GENERAL PLAN INFORMATION

Plan Name	Lincoln Intermediate Unit Section 125 Plan
Plan Type	Cafeteria Plan that includes a Health Flexible Spending Account, Dependent Care Assistance Plan and pre-tax premium contributions
Employer Identification Number	23-1743636
Plan Number	501
Plan Dates	January 1 st through December 31 st
Plan Sponsor	Lincoln Intermediate Unit 65 Billerbeck Street New Oxford, PA 17350
Plan Administrator	Lincoln Benefit Trust 65 Billerbeck Street New Oxford, Pennsylvania 17350
Named Fiduciary	Trust Manager Lincoln Benefit Trust 65 Billerbeck Street New Oxford, Pennsylvania 17350
Agent for Service of Legal Process	If, for any reason, the employee wants to seek legal action against the Plan, the employee can serve legal process on the Plan Administrator for the Plan.