Summary Plan Description
of
The Independence School, Inc.
Employee Benefit Plan

Introduction

This summary plan description is dated July 1, 2022.

The purpose of this summary plan description is to explain the provisions of The Independence School, Inc. (the "Employer") Employee Benefit Plan (the "Plan"). The Employer maintains this Plan for the exclusive benefit of its full-time employees and the spouses and eligible dependents of these employees. Participants are urged to read this document carefully.

The following Component Benefits are described in this Summary Plan Description:

- Medical;
- Dental;
- Vision;
- Long Term Disability;
- Life;
- Accidental Death & Dismemberment; and
- Telemedicine.

Generally, the terms and conditions under which an employee may be eligible for and receive the benefits are set forth in the terms of an insurance policy or service agreement. These benefit programs are summarized in a "certificate of insurance" or "booklet" issued by the insurance company or claims administrator (this summary is referred to in this document as the "Booklet"). A copy of this Booklet has been provided to each participating employee (referred to as a "Participant"). Additional copies are available upon request. All available options are listed on Attachment A, which is attached to and incorporated into this Summary Plan Description.

The benefits under the Plan are provided through insurance policies or through the Employer. The Employer is not an insurer of any fully-insured benefits. The payment of all fully-insured benefits will be made by the applicable insurance company. This document does not replace the provisions of the insurance policies that the Employer has purchased to provide benefits under the Plan. For self funded medical benefits, the payment will be made by the Employer through the Employer's general assets. Every effort has been made to make this Summary Plan Description as complete and accurate as possible. In the event of any difference between this Summary Plan Description and any insurance policy, service agreement, or Booklet, the terms of this Summary Plan Description will apply for purposes of determining eligibility and when coverage begins and ends, but the terms of the policy, or service agreement, or Booklet will apply for all other provisions.

For any questions about the benefits under the Plan, please contact the Employer using the contact information contained in the next section of this Summary Plan Description.

The Booklets for this plan are incorporated into this SPD by reference. These Booklets, along with any amendments or attachments, may contain the following information (as applicable):

- Additional procedures for enrolling in the Plan;
- A summary of benefits, though this may be provided as a separate document;
- A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of contributions, if any, to the premium payment will be provided by the Employer as a separate document;
- A description of any annual or lifetime caps or other limits on benefits;
- Whether and under what circumstances preventive services are covered;
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers (if any). If there is a network, the Booklet will contain a general description of the provider network and Participants will receive a list of providers in the network from the insurance companies or claims administrators. A list of network providers can also be found on the insurance company's or claims administrator's website, which is listed on Attachment A;
- Whether and under what circumstances coverage is provided for any out-of-network services;
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- Any services requiring preauthorization or utilization review as a condition to obtaining a benefit service;
- Provisions relating to termination of coverage;
- A summary of the claim procedures. However, if the claims procedures are not included in the Booklet, a copy will be provided without charge from the insurance company or claims administrator, as applicable;
- Provisions describing the coordination of benefits under this Plan with the benefits provided under another similar plan in which the Participant or his/her spouse are enrolled;
- Any subrogation or reimbursement rights of the insurance company or employer that prevent duplicate payments for health care or permit recovery of overpayments of benefits; and
- Any other benefit limitations and exclusions.

General Information about the Plan

Plan Name:	The Independence School, Inc. Employee Benefit Plan
Type of Plan:	Welfare plan providing medical, dental, vision, disability, life, and telemedicine benefits
Plan Year:	July 1st through June 30th
Plan Number:	501
Effective Date:	This Plan has been amended and restated as of July 1, 2022
Plan Sponsor:	The Independence School, Inc. 1300 Paper Mill Road Newark, DE 19713 (302) 239-0330
Name and Address of Other Participating Affiliated Employers:	None
Plan Sponsor's Employer Identification number:	51-0225189
Plan Administrator:	The Independence School, Inc. 1300 Paper Mill Road Newark, DE 19713 (302) 239-0330
Named Fiduciary:	The Independence School, Inc. 1300 Paper Mill Road Newark, DE 19713 Attention: Director of Finance (302) 239-0330
Agent for Service of Legal Process:	The Independence School, Inc. 1300 Paper Mill Road Newark, DE 19713 Attention: Director of Finance (302) 239-0330

General Information about the Benefits

Type of Benefits Available

See Attachment A for specific information about the types of benefits available under the Plan.

Funding of Benefits

Fully insured benefits are paid through one or more contracts of insurance. Insurance premiums for employees and their families are paid by the Employer out of its general assets. Employees are required to contribute toward the dental and vision premium on a pre-tax basis.

The medical benefits are paid by the employer out of its general assets and in part by pre-tax contributions by the employee.

Eligibility for and Termination of Coverage under the Plan

Eligibility for Coverage

All regular full-time employees of the Employer working at least thirty (30) hours per week are eligible for coverage.

Employees are eligible upon date of hire.

Please read the Eligibility provisions of the Booklet for more information about eligibility for coverage. Dependents are eligible in accordance with the provisions in the Booklet.

Qualified Medical Child Support Orders

An eligible dependent child may include a child for whom a Participant 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 participant or state or political subdivision acting on behalf of a child). The alternate recipient must be treated like any other plan participant.

Upon receipt of a child support order, the plan administrator will promptly send a written notice of receipt of the order to the participant and all alternate recipient children named in the order and their legal representatives. If the plan administrator receives a National Medical Support Notice, it must 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 plan administrator must also send a description of the coverage.

After sending the notice of receipt, the plan administrator has the ultimate authority to determine whether or not the order meets the requirements of a QMCSO. Within 40 days after receiving the order, the plan administrator will notify the participant 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.

Benefits for Dependents

To be eligible to enroll as a Dependent, a person must be: a) the lawful spouse of a Participant as defined by the laws of state in which the Employer is based; or b) the Participant's or Participant's lawful spouse's child(ren), including: newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.

Benefits for Spouses
Spouses are eligible for medical coverage only if the spouse is unemployed or the spouse is employed but is not eligible for medical coverage through the spouse's employer (or no coverage is available).

Enrollment
Eligible employees must enroll for coverage by filling out, signing and returning an enrollment form and/or salary reduction agreement. New employees must enroll within 30 days of initial eligibility or they will not be permitted to enroll until an annual enrollment period that is held each year, except as otherwise provided in the "Election Change" section below.

When Coverage Begins (Effective Date)
Coverage will begin on the first day of the month following the first day that all eligibility requirements are met if the employee enrolls as required above.

When Coverage Ends (Termination Date)
Medical, dental, vision, and telemedicine coverage terminates on the last day of the month coinciding with or following the last day of employment or the last day of the month coinciding with or following the date that the employee is no longer eligible.

Disability and life coverage terminates on the last day of employment or the date that the employee is no longer eligible.

In order to remain eligible for coverage under the Plan, a Participant must remain an eligible employee actively working for the Employer under the terms set forth above and in the Booklets, or in the Employer's employment policies, as applicable. In certain circumstances, after coverage terminates a Participant and/or his/her spouse and dependents may be eligible for continued coverage and/or a conversion policy, as explained in the following sections.

Continued Coverage under the FMLA (if applicable) and USERRA
Notwithstanding any other provision to the contrary, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA") or the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), medical benefits will continue to the extent required by the provisions of these laws. Participants will be required to continue to pay their portion of the premium for continued coverage as required by the FMLA and USERRA.

Except as otherwise provided in the FMLA, participation may be terminated by the Plan Administrator when notified that the Participant does not intend to return to work after the FMLA leave or at the end of the leave if the Participant does not return to work. However, coverage may be continued to comply with the Employer's leave of absence policies or if required by the Americans with Disabilities Act.

Coverage will be reinstated following a military leave as required by USERRA.

COBRA Continuation
If a Participant's medical, dental, or vision coverage (and/or the coverage of any dependent) terminates because of a life event known as a "qualifying event," then the Participant and eligible family members may have the right to purchase continued coverage for a temporary period of time. Qualifying events include termination of employment (other than for gross misconduct), reduction in hours, divorce, death, a child ceasing to meet the definition of dependent, or the Participant's or spouse's eligibility for Medicare (Part A, Part B or both).

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has received timely notification that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the Participant in Medicare, the Employer must notify the COBRA Administrator of the qualifying event within 30 days after the qualifying event or the loss of coverage. For other qualifying events, such as divorce or legal separation, or the dependent child's loss of eligibility for coverage as a dependent, the Participant or dependent must notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the loss of coverage. Notice must be provided as required by the initial COBRA notice which has been delivered by the Employer or the Employer's COBRA Administrator. If these procedures are not followed or if the notice is not provided within the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Once the Plan Administrator receives timely written notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage by the specified deadline, coverage will begin on the later of the date of the qualifying event or the date on which active coverage ceases.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, enrollment of the Participant in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months. When the qualifying event is the end of employment or reduction in the Participant's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period can be extended: (1) if the Participant or dependent covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion, the Participant and covered dependents can receive up to an additional 11 months of coverage for a total of 29 months. The Participant must notify the Plan Administrator within 60 days after the date of the determination, but before the end of the 18-month continuation period. (2) if any covered dependent experiences another qualifying event while receiving COBRA continuation coverage (such as death of the Participant or divorce), the spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months. (3) If a qualifying event that is termination of employment or reduction of hours occurs within 18 months after the Participant becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the Participant became entitled to Medicare (but the Participant's maximum coverage period will be 18 months).

For additional information about COBRA continuation rights and for any questions about COBRA, please read the initial COBRA notice, a copy of which has been provided to each Participant and his/her covered spouse. Participants can contact the Plan Administrator for another copy.

Election Changes

An Employee or Participant may change his/her election during a Plan Year only if one of the following events occurs and only to the extent that the election change is consistent with the event:

(1) the Employee/Participant experiences a Change in Status; Change in Status means (1) a change in the Employee's legal marital status, including marriage, divorce, death of spouse, legal separation or annulment; (2) change in the number of dependents, including birth, adoption, placement for adoption, and death; (3) change in employment status, including any employment status change affecting benefit eligibility of the employee, spouse or Dependent, such as termination or commencement of employment, change in hours, strike or lockout, and a change in worksite (but only if the benefit eligibility is lost or gained as a result of the event); (4) a dependent satisfies or ceases to satisfy any dependent eligibility requirements due to attainment of age, gain or loss of student status, marriage or any similar circumstances; and (5) residence change of employee, spouse or dependent affecting an employee's, spouse's or dependent's eligibility for coverage;

(2) 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 or loss of employer contributions;

(3) The Employee, spouse or a Dependent becomes entitled to coverage under Medicare;

(4) the Employee, spouse or a Dependent loses coverage under a Medicaid Plan under Title XIX of the Social Security Act;

(5) the Employee, spouse or a Dependent loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act;

(6) the Employee, spouse, or a Dependent is determined to be eligible for group health plan premium assistance under Medicaid or SCHIP plan;

(7) the Employee takes an FMLA leave of absence;

(8) the Employee receives a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order) requiring the Employee to provide coverage for a dependent or requiring another person to provide such coverage;

(9) There is a significant change in cost (whether an increase or decrease) in one of the Component Benefits. 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;

(10) There is a significant curtailment of coverage or an addition or significant improvement in a Component Benefit. 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 Component Benefit that entitles a Participant to make a corresponding election change. In the case of curtailment that results in a loss of coverage under any Component Benefit, the Employer may permit the Participant to withdraw from the Plan;

(11) 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;

(12) Employees may revoke or change their salary reduction elections in order to enroll in Exchange/Marketplace coverage during the Exchange/Marketplace annual open enrollment period or during an Exchange/Marketplace special enrollment period and such enrollment occurs immediately following group plan termination;

(13) Employees may revoke or change their salary reduction elections if the employee changes from full-time status to part-time status and is reasonably expected to remain in part-time status and the employee enrolls in another plan no later than the first day of the second full month following group plan termination.

An Employee/Participant may make a new election within 30 or 60 days of the occurrence of an event described in this section, as applicable (election changes for events listed under 4, 5, and 6 must be requested within 60 days and all others 30), but only if the election is made on account of and is consistent with the event and if the election is made within the specified time period.

Any deadlines for HIPAA special enrollment rights (number 2 above) that would have taken place within the outbreak period (March 1, 2020 through sixty (60) days after the government lifts the national state of emergency) are tolled. Employees have thirty (30) or sixty (60) days to request a HIPAA special enrollment right starting sixty (60) days after the national state of emergency is lifted.

Plan Notices

Benefits after Childbirth (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 requires group health plans, insurance companies, and HMO's that cover hospital stays following childbirth to provide coverage for a minimum period of time. In general, hospital coverage for the mother and newborn must be provided for a minimum of 48 hours following normal delivery, or 96 hours following a cesarean section. Group health plans may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

The Plan provides coverage in compliance with The Newborns' and Mothers' Health Protection Act.

Women's Health & Cancer Rights Act (WHCRA)

If the Participant or his/her spouse or dependent have had or are going to have a mastectomy, the individual may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances shown in the Booklet will apply.

Special Enrollment Rights

If an Employee declines enrollment for him/herself or his/her dependents (including spouse) because of other health insurance coverage, the Employee may in the future be able to enroll and enroll his/her dependents in this plan, provided that enrollment is requested within 30 days after the other coverage ends. In addition, if a Participant has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the Participant may be able to enroll and enroll his/her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

Any deadlines for HIPAA special enrollment rights (number 2 of the Election Change section above) that would have taken place within the outbreak period (March 1, 2020 through sixty (60) days after the government lifts the national state of emergency) are tolled. Employees have thirty (30) or sixty (60) days to request a HIPAA special enrollment right starting sixty (60) days after the national state of emergency is lifted.

Additional Information

Administration

The Employer is also the Plan Administrator. The Plan Administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing certain procedures, such as those for Qualified Medical Child Support Orders and COBRA notice requirements, preparing and distributing information explaining the Plan to Participants and Dependents, furnishing annual reports with respect to the administration of the Plan, keeping reports of claims and disbursements for claims under the Plan, modifying elections under the Plan, promulgating election and claim forms, and preparing and filing reports to applicable governmental agencies.

However, for benefits under the Plan that are fully insured, the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy.

Claims Procedures

Each insurance company or claims administrator will decide claims and make claim payments in accordance with its reasonable claims procedures, as required by federal and any applicable state laws. A complete description of the insurance company's or claims administrator's claims procedures can be found in the Booklet or can be obtained from the company.

For the calendar year 2020, deadlines for submission of claims are paused beginning March 1, 2020 and will continue starting sixty (60) days after the national emergency status is lifted.

Amendment and Termination of the Plan

The Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The insurance companies that provide benefits under the Plan may make changes to the Plan either as required by law, as requested by the Employer, or in their own discretion. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits.

No Contract of Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any Employee or Participant, or as a guarantee of any Employee or Participant to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its employees with or without cause.

Privacy and Security

The Plan will use a Participant's or Dependent's 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 Participant 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.

With respect to PHI, the Employer will:

- Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
- 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;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or benefit plan of the Employer unless authorized by the individual that is the subject of the PHI;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available upon request an accounting of disclosures;
- 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;
- 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:
    - A brief description of what happened including the date of the breach and the date of discovery, if known;
    - A description of the types of unsecured PHI that were involved in the breach;
    - Any steps the individual should take to protect him/herself from potential harm resulting from the breach;
    - A brief description of what the Employer is doing to investigate the breach in accordance with HIPAA breach notification requirements;
    - Contact procedures for individuals to ask questions or learn additional information
- 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;
- 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 with the breach occurred;
- 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
- 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:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- 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;
- Report to the Plan any security incident of which the Employer becomes aware; and
- Use methods to encrypt ePHI that are approved by the Department of Health and Human Services.

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.

Definitions.

"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.

"DHHS" means the federal Department of Health and Human Services.

"Electronic PHI" is health information about a plan participant 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.

"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.

"Payment" includes all activities regarding the provision of benefits under the Plan.

"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 Covered Entity or its business associate on behalf of the Health Plans. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.

"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.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information about the Plan and its Benefits

You are entitled to examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), any updated summary plan description and, if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

If there are more than 100 participants in the Plan, you are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

During any plan year in which the Employer is subject to COBRA, you are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Participant's Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court shall decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Document
of
The Independence School, Inc.
Employee Benefit Plan

Plan Document

THIS PLAN IS ADOPTED as of July 1, 2022 (the "Effective Date") by The Independence School, Inc., hereinafter referred to as the "Employer."

Introduction

Title.
This Plan shall be known as The Independence School, Inc. Employee Benefit Plan.

Effective Date.
The Plan is hereby amended and restated effective on the Effective Date shown above.

Type of Plan.
This Plan is intended to qualify as an employee welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Establishment and Purpose of the Plan. This Plan is established by the Employer for the exclusive benefit of its full-time employees and their spouses and eligible dependents. The Plan provides benefits (each a "Component Benefit") that are described in separate Summary Benefit Booklets and one or more Summary Plan Descriptions. The benefits provided by this plan are listed on Attachment A, which is attached to and made part of the Summary Plan Description. The Summary Booklets and one or more Summary Plan Descriptions are collectively referred to herein as the "Benefit Booklets". These Benefit Booklets are incorporated by reference into this Plan Document. The Benefit Booklets, along with this wrap plan document shall constitute the written plan document, as required under ERISA Section 402.

Plan Number. The Plan Number for this Plan is 501.

Eligibility and Participation

Eligibility and Election.
An eligible employee is any common law employee of the Employer who is eligible to participate under the terms of any Component Benefit. The Component Benefits may or may not require an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends, is included in Benefit Booklets of each Component Benefit. Any employee who is eligible.to participate in this Plan and follows the election procedures described in the applicable Benefit Booklet will be considered a "Participant" in this Plan.

Termination of Participation.
A Participant's benefits (along with the benefits of his or her eligible spouse and eligible dependents) will cease when the employee's participation in the Plan terminates or when the Plan itself terminates. The Benefit Booklets describe other circumstances that will result in termination of participation in this Plan, or in any Component Benefit.

Enrollment of Dependents.
The Employer reserves the right to request verification of dependent status as necessary to determine eligibility for Plan coverage. Dependents are eligible for coverage under a Component Benefit in accordance with the terms of such Component Benefit.

Continuation Coverage.
If health coverage for an employee or eligible dependent ceases because of a "qualifying event" or military deployment, or a qualified leave of absence under the Family and Medical Leave Act ("FMLA"), if applicable, then the employee and/or his or her eligible dependents may have a right to continue coverage in accordance with the terms of COBRA, USERRA or the FMLA. Details about continuation rights are included in the Benefit Booklets.

The medical, dental, and vision benefits may each be elected separately under COBRA continuation.

Cost of Coverage

The Component Benefits will be funded as described in the Benefit Booklets or other documents applicable to that benefit, but generally, the cost will be paid in part by the Employer out of its general assets.

Qualified Medical Child Support Orders

With respect to the Component Benefit that is a group health plan, the Plan will provide benefits as required by any qualified medical child support order (QMCSO). The Plan has procedures for determining whether an order qualifies as a QMCSO. These procedures are described in the Summary Plan Description where they are applicable. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employer.

Plan Administration

Plan Sponsor.
The Sponsor of this Plan is the Employer.

Plan Administrator.
The administration of the Plan is under the supervision of the Employer as Plan Administrator. The principal duty of the Plan Administrator is to ensure that the Plan is operated in accordance with its terms and for the exclusive benefit of those persons who are entitled to participate in the Plan. Other responsibilities of the Plan Administrator include interpreting the Plan, determining eligibility for coverage under the Plan, approving benefits and the amount of benefit payments, gathering information necessary for administering the Plan, and maintaining all records of the Plan. The Plan Administrator may delegate any of these administrative duties and responsibilities to one or more other entities.

Plan Amendment and Termination

The Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time by a written instrument adopted by the Employer.

Payment of Claims

Claim Filing.
To obtain payment of any benefits under the Plan, a Participant must comply with the rules and procedures of each Component Benefit elected under this Plan. The Employer or applicable claims administrator may require a Participant to complete and file an application for a benefit, and to furnish all related information.

Benefit Denials and Claims Procedures.
The procedures Participants are required to follow to file a complaint or grievance pertaining to denial of a claim for benefits or coverage are available to all Participants and beneficiaries, at no cost. For the calendar year 2020, appeals are paused beginning March 1, 2020 and will continue starting sixty (60) days after the national emergency status is lifted.

Health Insurance Portability and Accountability Act of 1996

Use and Disclosure of PHI.
The Plan will use a Participant's or Dependent's 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 Participant 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.

With respect to PHI, the Employer will:

- Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
- 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;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or benefit plan of the Employer unless authorized by the individual that is the subject of the PHI;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available upon request an accounting of disclosures;
- 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;
- 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:
    - A brief description of what happened including the date of the breach and the date of discovery, if known;
    - A description of the types of unsecured PHI that were involved in the breach;
    - Any steps the individual should take to protect him/herself from potential harm resulting from the breach;
    - A brief description of what the Employer is doing to investigate the breach in accordance with HIPAA breach notification requirements;
    - Contact procedures for individuals to ask questions or learn additional information
- 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;
- 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 with the breach occurred;
- 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
- 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:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- 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;
- Report to the Plan any security incident of which the Employer becomes aware; and
- Use methods to encrypt ePHI that are approved by the Department of Health and Human Services.

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.

Definitions.

"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.

"DHHS" means the federal Department of Health and Human Services.

"Electronic PHI" is health information about a plan participant 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.

"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.

"Payment" includes all activities regarding the provision of benefits under the Plan.

"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 Covered Entity or its business associate on behalf of the Health Plans. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.

"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.

Compliance with State and Federal Mandates

With respect to the Component Benefit and as applicable, the Plan will comply with the requirements of all applicable laws.

Insurance Contract or Governing Documents

Benefits are provided either through insurance contracts or pursuant to other governing documents issued by a Claims Administrator and adopted by the Employer.

The Employer has caused this Plan to be executed, effective as of July 1, 2022.

The Independence School, Inc.

By:_____

Title:_____

Attachment A
The Independence School, Inc.
Employee Benefit Plan
As of July 1, 2026

Medical

Option	Funding	Plan Type	Claims Administrator
	Self-funded	HDHP	Highmark of Delaware (800)633-2563 www.highmarkbcbsde.com

Dental

Option	Funding	Plan Type	Claims Administrator
	Insured through Dominion Dental	PPO	Dominion Dental 888-518-5338 www.dominionnational.com

Vision

Option	Funding	Plan Type	Claims Administrator
	Insured through Superior Vision		Superior Vision (800)507-3800 www.superiorvision.com

Long Term Disability

Option	Funding	Plan Type	Claims Administrator
	Insured through USAble		USAble (800)648-0271 www.usablelife.com

Life

Option	Funding	Plan Type	Claims Administrator
	Insured through USAble		USAble (800)648-0271 www.usablelife.com

Accidental Death & Dismemberment

Option	Funding	Plan Type	Claims Administrator

	Insured through USAble		USAble (800)648-0271 www.usablelife.com

Telemedicine

Option	Funding	Plan Type	Claims Administrator
	Insured through Healthiest You		Healthiest You 866-703-1259 www.healthiestyou.com

An employee's eligibility to participate in the plans listed above is dependent upon the provisions of each underlying plan.

Employer reserves the exclusive right to modify, delete from, or add to the above stated list of plans at any time and in accordance with all applicable laws.