

WELFARE EMPLOYEE BENEFIT PLAN DOCUMENTS

for

USD 260 – DERBY PUBLIC SCHOOLS

Documents prepared by:



USD 260 - DERBY PUBLIC SCHOOLS - SUMMARY OF WELFARE BENEFIT PLAN INFORMATION

Plan Name	Plan Number	Plan Funding	Insurance Company	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Plan Year	Premiums Paid
Welfare Benefit Plan	501	N/A	N/A	N/A	Regularly scheduled to work at least 20 hours per week.	1st day of the month following 30 days of employment.	Calendar	N/A
Medical Plan (non-grandfathered)	501	Fully-Insured	Blue Cross Blue Shield	204150789	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Part Employer Paid, part Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Dental Plan	501	Fully-Insured	Delta Dental of Kansas	00186-000-00001-00000	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Health Flexible Spending Account	501	Self-Funded	Claims Administrator: Surency Life & Health	N/A	Same as Welfare Benefit Plan, except that employees in the AmeriCorp program are not eligible.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Dependent Care Assistance Plan	501	Self-Funded	Claims Administrator: Surency Life & Health	N/A	Same as Welfare Benefit Plan, except that employees in the AmeriCorp program are not eligible.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.

USD 260 - DERBY PUBLIC SCHOOLS - SUMMARY OF WELFARE BENEFIT PLAN INFORMATION

Plan Name	Plan Number	Plan Funding	Insurance Company	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Plan Year	Premiums Paid
Vision Plan	501	Fully-Insured	Surency Life & Health	00186-000-00001-00000	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Group Life Plan	501	Fully-Insured	Guardian	569620	Same as Welfare Benefit Plan, except that employees in the AmeriCorp program are not eligible.	Same as Welfare Benefit Plan.	Calendar	Employer Paid (Employee not taxed on premiums).
Voluntary Life Plan	501	Fully-Insured	Guardian	569620	Same as Welfare Benefit Plan, except that employees in the AmeriCorp program are not eligible.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on an After-Tax basis through Welfare Benefit Plan.
Short Term Disability Plan	501	Fully-Insured	Guardian	569620	Same as Welfare Benefit Plan, except that employees in the AmeriCorp program are not eligible.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on an After-Tax basis through Welfare Benefit Plan.
Critical Illness Plan	501	Fully-Insured	AFLAC	Individual Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.

USD 260 - DERBY PUBLIC SCHOOLS - SUMMARY OF WELFARE BENEFIT PLAN INFORMATION

Plan Name	Plan Number	Plan Funding	Insurance Company	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Plan Year	Premiums Paid
Accident Plan	501	Fully-Insured	AFLAC	Individual Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Hospital Indemnity Plan	501	Fully-Insured	AFLAC	Individual Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Legal Services Plan	501	Fully-Insured	LegalShield	N/A	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on an After-Tax basis through Welfare Benefit Plan.
3-in-1 Plan (accident, critical illness, and hospital benefits)	501	Fully-Insured	Reliance Standard	Accident - VAI 826285 Critical Illness - VCI 801194 Hospital - VHI 000071	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	Calendar	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.

USD 260 - DERBY PUBLIC SCHOOLS

WELFARE BENEFIT PLAN

USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN

USD 260 – Derby Public Schools (“Employer”) adopts this amended and restated USD 260 – Derby Public Schools Welfare Benefit Plan (“Plan”) for the benefit of its Eligible Employees. This Plan is an amendment and restatement of the Plan originally adopted effective January 1, 1980, as subsequently amended and restated effective January 1, 2020.

ARTICLE I PURPOSE AND LEGAL STATUS OF THE PLAN

Section 1.01 Purpose of Plan. The purpose of this Plan is to provide Eligible Employees of the Employer a choice between taxable compensation and nontaxable benefits, and after-tax benefits offered by the Employer. Additionally, this Plan provides certain employer paid benefits to Eligible Employees of the Employer.

Section 1.02 Cafeteria Plan Status. It is the intent of the Employer that this Plan qualify as a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code, as amended, and the regulations issued thereunder, and that any “qualified benefits” paid under this Plan be eligible for exclusion from the Participant’s gross income for federal income tax purposes.

Section 1.03 Exclusive Benefit. It is intended that the Plan terms, including those related to coverage and benefits, be legally enforceable and that this Plan be maintained for the exclusive benefit of Employees and their covered dependents.

Section 1.04 Status of Plan. It is the intent of the Employer that this Plan, including any underlying Benefit Package Options, be considered to be a single plan. For purposes of COBRA continuation rights, however, each underlying Benefit Package Option shall be considered to be a separate plan.

ARTICLE II DEFINITIONS

Section 2.01 “After-Tax Benefit” means one or more of the following plans:

- (a) USD 260 – Derby Public Schools Voluntary Life Plan (“Voluntary Life Plan”);
- (b) USD 260 – Derby Public Schools Short Term Disability Plan (“Short Term Disability Plan”); and
- (c) USD 260 – Derby Public Schools Legal Services Plan (“Legal Services Plan”).

Section 2.02 “Annual Enrollment Period” means the period defined in Section 5.03(b) of this Plan.

Section 2.03 “Benefit Package Option” means a benefit that is offered under this Plan on a pre-tax basis or an option for coverage that is offered under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

Section 2.04 “Claim” means any formal request for a Plan benefit or benefits made by a Claimant or his/her representative in accordance with the Plan’s procedures for filing benefit claims as set forth in Appendix C. A Claim does not include a request for a determination of an individual’s eligibility to participate in the Plan, nor does it include a casual inquiry regarding the scope of coverage under the Plan. A communication regarding benefits that is not made in accordance with the Plan’s procedures for filing a Claim will not be treated as a Claim.

Section 2.05 “Claimant” means a Participant who files a Claim for benefits pursuant to Appendix C of this Plan.

Section 2.06 “Claims Administrator” means the Plan Administrator, unless the Employer retains another person to serve as the claims fiduciary for a Pre-Tax Benefit choice, After-Tax Benefit choice, or an Employer Paid Benefit choice with the authority to grant or deny claims for benefits.

Section 2.07 “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.08 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.09 “Compensation” means wages, salary and other remuneration paid to a Participant by the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan or 403(b) plan or arrangements on behalf of the Participant, and does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.10 “Effective Date” means the original date on which this Plan took effect, which date is January 1, 1980; provided, however, that if this Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.11 “Election Change Event” means an event which would allow a Participant to change the Participant’s elections during a Plan Year, subject to the requirements of Article V and as set forth in more detail in Sections 5.06 through 5.15.

Section 2.12 “Eligible Employee” means an Employee, other than a Temporary Employee, actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding twenty (20) hours per week, subject, however, to the following:

(a) Special Rules:

- (i) *Seasonal Employees and Substitutes.* Seasonal Employees and Substitute Teachers are not Eligible Employees under this Plan;
- (ii) *Status During Leaves of Absence.* An Employee’s status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer; during an unpaid leave of absence not to exceed the end of the month, or, if the FMLA is applicable to the Employer, during a leave of absence taken pursuant to the FMLA provided, however, any period of unpaid leave shall run concurrently with any FMLA leave;
- (iii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as “unpaid leave” for purposes of plan eligibility. However, nothing in this subsection shall preclude a Participant on FMLA leave from maintaining eligibility during such FMLA leave;
- (iv) *Special Rule for Employees in AmeriCorp.* Eligible Employees who are in the AmeriCorp program will not be eligible for Health FSA, DCAP, Group Life Plan, Voluntary Life Plan, or Short Term Disability Plan that are provided under the Plan;
- (v) *Status During Military Service.* An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less; and
- (vi) *Medical, Dental, and Vision Plans.* An Eligible Employee who is participating in the Medical, Dental, and/or Vision Plans and who terminates employment with the Employer before the end of the month will continue to participate in this Plan for purposes of participating in the Medical, Dental, and/or Vision Plans on a pre-tax basis through the end of the month in which the termination occurs.

- (b) Any individual who is, with respect to the Employer, (i) a self-employed individual, or (ii) a more-than-two-percent shareholder of an S corporation under Section 1372(b) of the Code shall not be an Eligible Employee for purposes of making pre-tax salary reductions pursuant to Article V. However, such individual shall be an Eligible Employee for purposes of participating in underlying Benefits *on an after-tax basis*.

Note: The underlying Benefits may have additional eligibility requirements. Such additional requirements, if any, are set forth separately in this Plan document.

Section 2.13 “Employee” means an individual employed by the Employer, excluding those persons covered by a collective bargaining agreement and further excluding those persons classified by the Employer on its payroll records as “leased employees” as that term is used in Section 414(n) of the Code.

Section 2.14 “Employer” means USD 260 – Derby Public Schools.

Section 2.15 “Employer Paid Benefit” means the USD 260 – Derby Public Schools Group Life Plan (“Group Life Plan”).

Section 2.16 “FMLA” means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.17 “Group Health Plan” means, for purposes of the HIPAA, COBRA, and FMLA provisions in Articles III, V, VII, and VIII, a Pre-Tax Benefit Plan, an After-Tax Benefit Plan or an Employer Paid Benefit Plan that provides health care to the Participants in the Plan and their beneficiaries. The term includes the following benefits:

- (a) USD 260 – Derby Public Schools Medical Plan (“Medical Plan”);
- (b) USD 260 – Derby Public Schools Dental Plan (“Dental Plan”);
- (c) USD 260 – Derby Public Schools Health Flexible Spending Account (“Health FSA”); and
- (d) USD 260 – Derby Public Schools Vision Plan (“Vision Plan”).

Section 2.18 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.19 “Participant” means an Eligible Employee who has entered the Plan pursuant to Section 3.01 and whose participation in the Plan has not been terminated pursuant to Section 3.02.

Section 2.20 “Plan” means the USD 260 – Derby Public Schools Welfare Benefit Plan.

Section 2.21 “Plan Administrator” means the Employer. The Employer may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this Plan in a manner consistent with the terms of this Plan and ERISA.

Section 2.22 “Plan Year” means the fiscal year of this Plan, the twelve (12) consecutive month period beginning every January 1 and ending the subsequent December 31.

Section 2.23 “Pre-Tax Benefits” means one or more of the following:

- (a) USD 260 – Derby Public Schools Medical Plan;
- (b) USD 260 – Derby Public Schools Dental Plan;
- (c) USD 260 – Derby Public Schools Health Flexible Spending Account;
- (d) USD 260 – Derby Public Schools Dependent Care Assistance Plan (“DCAP”);
- (e) USD 260 – Derby Public Schools Vision Plan;
- (f) USD 260 – Derby Public Schools AFLAC Pre-Tax Plan (“AFLAC Pre-Tax Plan”); and
- (g) USD 260 – Derby Public Schools 3-in-1 Plan (“3-in-1 Plan”).

Section 2.24 “Spouse” means a person of the same or opposite sex to whom an Eligible Employee is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a “Spouse” for purposes of this Plan if (a) his/her marriage to the Eligible Employee has been terminated by a court having jurisdiction over one or both parties to the marriage or (b) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

Section 2.25 “Seasonal Employee” means an employee who is hired into a position for which the customary annual employment is six (6) months or less.

Section 2.26 “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE III PARTICIPATION IN THE PLAN

Section 3.01 Entry into the Plan.

- (a) *General Rule.* An Eligible Employee becomes a Participant on the first day of the month following thirty (30) days of continuous, active employment as an Eligible Employee.

An Eligible Employee who has entered into the Plan pursuant to this Section is a Participant without regard to whether he/she elects to reduce his/her Compensation in order to purchase benefits under one or more of the Benefits under this Plan.

- (b) *Special Rule for Employees in the AmeriCorp Program.* An Eligible Employee who participates in the AmeriCorp program will enter the Plan on the first day of the month following the date of hire. This Special Rule applies despite the General Rule set forth in 3.01(a) above.
- (c) *Effective Date of this Plan.* Notwithstanding any other provision of this Plan, no Eligible Employee may become a Participant prior to the Effective Date of this Plan.
- (d) *Rehired Participants.* If a Participant terminates employment, is later rehired, and becomes an Eligible Employee after being rehired, the former Participant will again become a Participant in the Plan pursuant to the provisions of Section 3.01(a). The elections of a former Participant who reenters the Plan within thirty (30) days after the date on which he or she ceased to be a Participant are subject to the provisions of Section 5.20.

Section 3.02 Termination of Participation.

- (a) *General Rule.* A Participant will cease participation in this Plan on the earlier of the following dates:
- (i) The date on which this Plan terminates; or
 - (ii) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this Plan terminates on the above date, coverage or benefits under the Pre-Tax, After-Tax, and Employer Paid Benefits may continue if and to the extent provided by such Pre-Tax, After-Tax, and Employer Paid Benefits.

Section 3.03 Family and Medical Leave Act of 1993.

- (a) *General Rule.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain the Participant's

benefits under a Group Health Plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). If the Participant is a participant in the Health FSA, additional rules may apply to the Participant's coverage under the Health FSA as set forth in the Appendix for the Health FSA.

- (b) *Options for Payment of Participant's Share of the Premium.* If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one or more of the following ways:
 - (i) The Participant may pay his/her share of the premiums with after-tax dollars while on leave (or with pre-tax dollars to the extent the Employee receives Compensation during the leave).
 - (ii) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.
- (c) *Return from FMLA Leave.* If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that the Participant was participating in the Plan prior to his/her leave, or as otherwise required by the FMLA.
- (d) *Failure to Pay Premiums While on FMLA Leave.* If the Participant fails to remit his/her premium payments within thirty (30) days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate the Participant's coverage retroactive to the date the unpaid premium payment was due.

ARTICLE IV PLAN BENEFITS

Section 4.01 Pre-Tax Benefits. Each Participant may elect to reduce his or her Compensation and have the amount applied by the Employer toward the cost of benefits available under one or more of the Pre-Tax Benefits under this Plan. For those benefits that are provided through a policy of insurance, the monthly premiums are determined by the applicable insurance company and may change from time to time.

- (a) *Terms and Conditions of the Pre-Tax Benefits*. The terms and conditions of the Pre-Tax Benefits are as follows:
 - (i) *Medical Plan*. Participants may elect to receive medical coverage through the Medical Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix A.
 - (ii) *Dental Plan*. Participants may elect to receive dental coverage through the Dental Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix B.
 - (iii) *Health Flexible Spending Account*. Participants may elect to make contributions to the Health FSA. A Health FSA enables Participants to elect pre-tax salary reduction and receive reimbursements for their unreimbursed Qualified Medical Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 105(h) of the Code so that the Employer's reimbursements from the Health FSA are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix C.
 - (iv) *Dependent Care Assistance Plan*. Participants may elect to make contributions to the DCAP. A DCAP enables Participants to elect pre-tax salary reduction and receive reimbursements for their Qualified Dependent Care Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 129 of the Code so that the Employer's reimbursements from the DCAP are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix D.
 - (v) *Vision Plan*. Participants may elect to receive vision insurance through the Vision Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix E.
 - (vi) *AFLAC Pre-Tax Plan*. Participants may elect to receive critical illness coverage, accident coverage, and hospital indemnity coverage through individual policies under the AFLAC Pre-Tax Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix I.

- (vii) *3-in-1 Plan.* Participants may elect to receive accident, critical illness, and hospital benefits through the 3-in-1 Plan. The terms and conditions of this Pre-Tax Benefit are provided in Appendix K.
- (b) *Election of Pre-Tax Benefits.* The election of a Pre-Tax Benefit is subject to the terms and conditions of Article V.
- (c) *Cessation of Participation in a Pre-Tax Benefit.* Except as otherwise expressly provided in the Pre-Tax Benefit, a Participant will cease to be a Participant in the Pre-Tax Benefit on the date that he or she ceases to be a Participant in this Plan.

Section 4.02 After-Tax Benefits. Each Participant may elect to have the cost of one or more of the After-Tax Benefits deducted from his/her Compensation on an after-tax basis. The monthly premiums for insurance coverage are determined by the applicable insurance company and may change from time to time.

- (a) *Terms and Conditions of the After-Tax Benefits.* The terms and conditions of the After-Tax Benefits are as follows:
 - (i) *Voluntary Life Plan.* Participants may elect to receive life insurance through the Voluntary Life Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix G.
 - (ii) *Short Term Disability Plan.* Participants may elect to receive short term disability benefits through the Short Term Disability Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix H.
 - (iii) *Legal Services Plan.* Participants may elect to receive legal benefits through the Legal Services Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix J.
- (b) *Election of After-Tax Benefits.* A Participant may make and/or change his/her elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such election change shall take effect on the earliest administratively practicable date after the request to change an after-tax election is received by the Plan Administrator.

Section 4.03 Employer Paid Benefits. In addition to the optional benefits set forth in Sections 4.01 and 4.02, the Employer may choose to provide selected benefits to its Eligible Employees. Except as otherwise expressly provided in the Employer Paid Benefits below, a Participant will cease to be a Participant in such Employer Paid Benefits on the date that he or she ceases to be a Participant in this Plan. The USD 260 – Derby Public Schools Group Life Plan is an Employer Paid Benefit under Appendix F.

ARTICLE V ELECTION OF PRE-TAX BENEFITS

Section 5.01 Benefit Plans. Each Participant may elect to receive the Participant's entire Compensation in cash or to reduce the Participant's Compensation and have the Employer apply the amount by which the Participant's Compensation is reduced toward the cost of benefits that are available on a pre-tax basis under this Plan.

Section 5.02 Method of Making an Election. In order to purchase a Pre-Tax Benefit through this Plan, a Participant must execute an agreement to reduce his/her Compensation on the salary reduction form provided by the Plan Administrator. The Plan Administrator may require such agreement to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

Section 5.03 Timing of Elections.

- (a) *Initial Elections for Newly Eligible Employees.* To make an election to purchase Pre-Tax Benefits through this Plan, a newly Eligible Employee must execute a salary reduction form and deliver it to the Plan Administrator prior to the date he/she becomes a Participant in this Plan. The election will be given effect as of the earliest administratively practicable date next following the date on which the Eligible Employee delivers the salary reduction form to the Plan Administrator, provided that no such election may take effect prior to the date the Participant becomes a Participant in this Plan.
- (b) *Annual Elections for Current Participants.* At least thirty (30) days prior to the beginning of each Plan Year, the Plan Administrator must provide each Participant with the opportunity to make elections for the following Plan Year. Participants desiring to make elections during the Annual Enrollment Period for the next Plan Year must do so in the manner and within the deadlines prescribed by the Plan Administrator. Elections made during the Annual Enrollment Period shall become effective for the following Plan Year.
- (c) *Election Changes during a Plan Year.* A Participant may change his/her elections with respect to a Pre-Tax Benefit during a Plan Year *only if* an election change is permitted as a result of one or more of the events listed in Sections 5.06 through 5.15. Such events may be referred to generally in Plan documents as an "Election Change Event." Except as otherwise provided in this Article V, any election change as a result of an event qualifying as an Election Change Event must be made no later than thirty (30) days after the event. Election changes made as a result of an Election Change Event may *not* be given retroactive effect except as specifically set forth below. Additional restrictions and/or rules may apply to election changes made during a Plan Year with respect to a Health FSA and/or a DCAP.

Section 5.04 Failure to Make an Election.

- (a) *Failure to Make Initial Election.* A Participant's failure to return a completed salary reduction form by the required date as set forth in Section 5.03(a) constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash. In such an event, no portion of the Employee's Compensation will be applied toward the cost of any benefits available under any of the Pre-Tax Benefits. Such an Employee will not be permitted to change such an election until (i) the next Annual Enrollment Period or (ii) the Employee experiences an Election Change Event, as a result of which an election change would be permitted under this Article V.
- (b) *Failure to Change Existing Elections During Annual Enrollment Period.* Once a Participant has completed a salary reduction form for a Plan Year, a failure to complete a new form for a subsequent Plan Year during the Annual Enrollment Period shall be considered to be an election to participate on the same basis as the prior Plan Year, subject, however, to the following rules:
 - (i) *Change in Cost.* If the cost of the benefits elected by the Participant under one or more Pre-Tax Benefits during the current Plan Year has increased or decreased for the subsequent Plan Year, the Participant's election may be modified for the subsequent Plan Year by the amount of any such increase or decrease.
 - (ii) *Spending Account Plans.* If the Participant has elected to participate in the Health FSA and/or the DCAP during the current Plan Year, but has failed to complete a new election for a subsequent Plan Year, the Participant's election with respect to such Plans will be reduced to zero dollars for any subsequent Plan Years.

Section 5.05 Irrevocability of an Election Once Made. Once the Annual Enrollment Period has passed, a Participant shall not be permitted to revoke, amend, or change the elections the Participant has made for the affected Plan Year except as provided in this Article V.

Section 5.06 Election Change Due to Change in Status. After a Plan Year has commenced, a Participant shall be permitted to revoke an election in its entirety (or revoke the election and make a new election) for the balance of that Plan Year, if the Participant experiences a Change in Status as defined below and the consistency requirements of this Section 5.06 are satisfied.

- (a) *Change in Status.* The following events constitute a Change in Status:
 - (i) *Change in Marital Status.* A change in the Participant's legal marital status, including the following: Marriage, divorce, the death of a Spouse, legal separation, and annulment.
 - (ii) *Change in Number of Dependents.* A change in the number of the Participant's dependents, including the following: Birth, death, adoption, and placement for adoption.

- (iii) *Change in Employment Status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's dependents:
 - (A) A termination or commencement of employment;
 - (B) A commencement of or return from an unpaid leave of absence;
 - (C) A change in worksite, if such a change affects eligibility under this Plan or a Pre-Tax Benefit;
 - (D) A change in employment status, such as a change from salaried to hourly employment, if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's dependents under this Plan or under a Pre-Tax Benefit or if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's dependents under a cafeteria plan or welfare benefit plan maintained by an employer (other than the Employer) employing the Participant, the Participant's Spouse, or the Participant's dependents; or
 - (E) A strike or lockout.
- (iv) *Change in Dependent Eligibility.* An event that causes the Participant's dependent(s) to satisfy or cease to satisfy the eligibility conditions for coverage under a Pre-Tax Benefit on account of the dependent's attainment of a certain age, student status, or any similar circumstances.
- (v) *Change in Residence.* A change in the place of residence of the Participant, the Participant's Spouse, or the Participant's dependent(s), if such a change affects eligibility under this Plan or a Pre-Tax Benefit.
- (b) *Consistency.* An election change that is made on account of a Change in Status must be consistent with that Change in Status. Whether a particular election change is consistent with a Change in Status will be determined by the Plan Administrator in accordance with Internal Revenue Service regulations.

Section 5.07 Election Change Due to Exercise of HIPAA Special Enrollment Rights.

- (a) *HIPAA Special Enrollment Rights.* After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage, if the Participant, the Participant's Spouse, or a dependent of the Participant is entitled to special enrollment rights under a group health plan of the Employer as described under either (i), (ii), (iii), or (iv) below:
 - (i) *Eligibility for a State Premium Assistance Subsidy under the Plan from Medicaid or SCHIP.* A Participant or his/her Spouse or dependent becomes eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP);

- (ii) *Loss of Eligibility for Medicaid or SCHIP Coverage.* The Medicaid or SCHIP coverage of a Participant or his/her Spouse or dependent is terminated as a result of a loss of eligibility.
- (iii) *Loss of Other Coverage.* Medical coverage was declined under a group health plan sponsored by the Employer because the Employee and/or dependent was covered under another group health plan or had other health insurance coverage, and eligibility for such coverage is subsequently lost. A loss of eligibility for such other coverage includes the following:
 - (A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period;
 - (B) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area (whether or not the choice of the individual); and
 - (C) In the case of coverage offered through an HMO in the group market that does not provide benefits to an individual who no longer resides, lives or works in the service area (whether or not the choice of the individual), and no other benefit package is available to the individual.

A loss of eligibility does not include a loss resulting from the failure of the Employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

- (iv) *Acquisition of a New Dependent.* The Participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption.
- (b) *New Election Must Correspond and be Consistent with HIPAA Special Enrollment Rights.* A change in elections pursuant to this Section 5.07 must correspond and be consistent with the exercise of the special enrollment rights provided under Code § 9801(f).
 - (i) *Increase in Salary Reductions.* A Participant may elect to increase the amount by which his or her Compensation is reduced by no more than the additional cost of the benefits provided under the group health plan as a result of the enrollment of the Participant, the Participant's Spouse, and/or a dependent of the Participant in the group health plan.
 - (ii) *Decrease in Salary Reductions.* A Participant may elect to decrease the amount by which his/her Compensation is reduced by no more than the cost of the premium assistance received by the Participant and/or his/her dependents.
 - (iii) *Election to Add Previously Eligible Dependents.* An election to add previously eligible dependents as a result of a loss of other coverage or the acquisition of a new Spouse or dependent child shall be considered to be consistent with the special enrollment rights.

- (c) *Status Change Form.* Each Participant must complete a status change form and submit such form to the Plan Administrator no later than sixty (60) days after the date of the event giving rise to the exercise of a HIPAA special enrollment right under (a)(i) or (a)(ii) above, or no later than thirty (30) days after the date of the event giving rise to the right to exercise the special enrollment rights under (a)(iii) or (a)(iv) above.
- (d) *Effective Date of Medicaid/SCHIP Provisions.* The effective date of the HIPAA special enrollment right provisions set forth in Subsections (a)(i) and (a)(ii) is April 1, 2009.
- (e) *Approval of Change.* Any change in election resulting from the exercise of the special enrollment rights provided under Code § 9801(f) is subject to the review and approval of the Plan Administrator.

Section 5.08 Enrollment in a Qualified Health Plan Under the Marketplace. The Participant enrolls in a Qualified Health Plan through an Exchange / Health Insurance Marketplace (the "Marketplace") established pursuant to the Patient Protection & Affordable Care Act by virtue of having become eligible for a Special Enrollment Period in the Marketplace or having enrolled during the Marketplace's annual open enrollment period, so long as both of the following conditions are satisfied:

- (a) The revocation of the Participant's election corresponds to the intended enrollment of the Participant, and any Spouse or dependents who cease coverage due to the revocation, in a Qualified Health Plan through the Marketplace; and
- (b) The new coverage under the Marketplace's Qualified Health Plan in which the Participant (and, if applicable, the Participant's Spouse and/or dependents) enrolls takes effect no later than the day immediately following the day that the Participant's coverage under the Medical Plan is terminated. (The Plan Administrator may rely on the Participant's reasonable representations regarding the intention to enroll in a Qualified Health Plan under the Marketplace and the effective date of such coverage.)

Section 5.09 Election Change Due to Change in Coverage (Does not apply to Health FSA).

- (a) *Cessation or Significant Curtailment in Coverage.*
 - (i) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed (but not lost) during the Plan Year, the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the plan so as to constitute reduced coverage to Participants in general.

- (ii) *Significant Curtailment With Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed during the Plan Year and that the curtailment constitutes a loss of coverage with respect to a Participant (or the Participant's Spouse or dependent), the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. If no similar Benefit Package Option is available, the Participant may elect to drop coverage. For purposes of this Section 5.09(a)(ii), a loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefits Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion and in accordance with prevailing Internal Revenue Service guidance, may determine that the following constitutes a loss of coverage:
 - (A) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);
 - (B) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's Spouse or dependent is currently in a course of treatment; or
 - (C) Any other similar fundamental loss of coverage.
 - (iii) *Determinations to be Made by the Plan Administrator.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance and based upon the surrounding facts and circumstances, whether a curtailment is "significant," whether a curtailment represents a loss of coverage with respect to a particular individual, and whether a substitute Benefit Package Option provides "similar coverage."
- (b) *Addition or Improvement of a Benefit Package Option.* If, during the Plan Year, a new Benefit Package Option or a new coverage option is added, or if coverage under an existing Benefit Package Option or existing coverage option is significantly improved during the period of coverage, a Participant may elect to add the new Benefit Package Option/coverage option, or the improved Benefit Package Option/coverage option, and to make corresponding changes with respect to other Benefit Package Options providing similar coverage. Any such change will take effect on a prospective basis only. The Plan Administrator, in its sole

discretion, shall decide, based upon the surrounding facts and circumstances and in accordance with prevailing Internal Revenue Service guidance, whether a new Benefit Package Option/coverage option has been added, whether an existing Benefit Package Option/coverage option has been significantly improved, and/or whether another Benefit Package Option/coverage option constitutes “similar coverage.”

- (c) *Change in Coverage of Spouse or Dependent under Plan of Another Employer (“Election Lock”).* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only if the change is on account of and corresponds with a change made under the plan of the employer of the Participant’s Spouse, the Participant’s former Spouse, or the Participant’s dependent. Any such change is permitted only if (i) the cafeteria plan of such other employer permits its participants to make only those election changes that are permitted under proposed or final Internal Revenue Service regulations under Code Section 125; or (ii) the period of coverage under the plan of such other employer is different than the Plan Year for this Plan. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change made under the plan of the employer of the Participant’s Spouse, former Spouse, or dependent. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination.
- (d) *Loss of Coverage Under Other Group Health Coverage.* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only to add coverage for the Participant or the Participant’s Spouse or dependent if the Participant or the Participant’s Spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution. For purposes of this provision, this includes the following: (i) A state’s children’s health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government or a tribal organization; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

Section 5.10 Election Change Due to FMLA Leave. A Participant who is taking leave under the FMLA may revoke an existing election of accident or health plan coverage and may make such other election for the remaining portion of coverage as may be permitted under Section 3.03 of this Plan. Additionally, such a Participant may also be permitted to change his/her elections under Section 5.06(a)(iii), provided the requirements of that section are satisfied.

Section 5.11 Election Change Due to Issuance of a Judgment, Decree or Order. If a judgment, decree, or order (an “Order”) resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage to be provided for a Participant’s dependent child, including a foster child who is a dependent of the Participant, a Participant may (a) change his/her election to provide coverage for

the dependent child, provided that the Order requires the Participant to provide such coverage; or (b) change his/her election to revoke coverage for the dependent child if the Order requires that another individual, including the Participant's Spouse or former Spouse, provide coverage under that individual's plan for the dependent child and such coverage is, in fact, provided.

Section 5.12 Election Change Due to Medicare/Medicaid Entitlement. If a Participant, a Participant's Spouse, or a Participant's dependent who is entitled to receive benefits under a Group Health Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits of Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may reduce his/her election to reflect the reduction or cancellation of the coverage provided to such person under the Group Health Plan. Additionally, if a Participant, a Participant's Spouse, or a Participant's dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may increase his/her election to reflect the increased cost of providing coverage under the Group Health Plan. Any change made under this Section 5.12 shall take effect on a prospective basis only. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination. The right to drop or add coverage under a Group Health Plan is governed by and subject to the terms of the Group Health Plan. This Section 5.12 does not apply to a Health FSA.

Section 5.13 Election Change Due to Significant Change in Cost.

- (a) *Increase in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) increases by a significant amount during a Plan Year, the Participant may either increase his/her election by a corresponding amount on a prospective basis or the Participant may revoke his/her election and, in lieu thereof, receive coverage under another Benefit Package Option (if any) providing similar coverage. If similar coverage is not available under another Benefit Package Option, the Participant may revoke his/her election without electing coverage under another Benefit Package Option.
- (b) *Decrease in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) decreases by a significant amount during a Plan Year, the Participant may decrease his/her election by a corresponding amount on a prospective basis or, if the Participant is not currently enrolled in the Benefit Package Option, the Participant may elect to become covered under that Benefit Package Option.
- (c) *Other Provisions.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a change in cost is significant and what constitutes "similar coverage" based upon all of the surrounding facts and circumstances.
- (d) *Special Provisions Applicable to DCAP's.* This Section 5.13 does not apply to a DCAP unless the change in cost is imposed by a dependent care provider who is not related (as that term is used in Internal Revenue Service Regulations) to the Participant.

Section 5.14 Election Change Required by the Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount by which they have elected to reduce their Compensation for a Plan Year if the Plan Administrator determines such action is necessary or advisable to (a) satisfy any Code nondiscrimination requirements applicable to this Plan or any Pre-Tax Benefit; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits from any Pre-Tax Benefit than would otherwise be recognized; or (c) maintain the qualified status of benefits received under this Plan. In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the amount by which each affected Participant has elected to reduce his/her Compensation, beginning with the Participant in the class who had elected to reduce his/her Compensation by the highest amount, continuing with the Participant in the class who had elected the next highest amount, and so forth, until the defect is corrected.

Section 5.15 Automatic Election Change for Insignificant Changes in Cost. If the Participant's share of the premium or cost for the benefits provided under a Pre-Tax Benefit increases or decreases during the Plan Year by an insignificant amount, the Participant's election shall be increased or decreased on a prospective basis by the amount of such increase or decrease. The Plan Administrator, on a reasonable and consistent basis, shall automatically effectuate this prospective increase or decrease in the elective contributions of the affected Participants in accordance with such cost changes. The Plan Administrator, in its sole discretion, shall decide whether increases or decreases in cost are "insignificant" based upon all of the surrounding facts and circumstances, including, but not limited to, the dollar amount and/or the percentage amount of the change.

Section 5.16 Requesting and Approving Election Changes. A Participant desiring to make a change in his/her elections pursuant to this Article V must complete and submit a status change form and/or such other forms as the Plan Administrator may require. If an election change is to take effect during a Plan Year, the Plan Administrator may require the Participant to provide such proof as it reasonably considers necessary of the events underlying the request for an election change, including, but not limited to, a marriage certificate, divorce decree, birth certificate, confirming letter from the Spouse's current or former employer, or any other relevant documents. All such requests for an election change must be reviewed and approved by the Plan Administrator before the election change is given effect. All such requests must be submitted within thirty (30) days after the date giving rise to the request for an election change, except as provided in Section 5.07(c) with regard to certain HIPAA special enrollment rights that allow such requests to be submitted within sixty (60) days after the date giving rise to the request for an election change.

Section 5.17 Effective Date of Election Changes. Except as specifically provided in this Section 5.17, an election change made during the middle of a Plan Year will be given prospective effect only and will take effect as of the first administratively practicable date following the date on which the Plan Administrator approves the new elections that are being made.

- (a) *Special Rule for Newly Adopted Dependent Children and Newborns.* Notwithstanding the general rule stated in this Section 5.17, and subject to the provisions of the underlying Group Health Plan, an election to increase the

amount by which the Participant's Compensation is reduced in order to fund the increased cost of providing benefits under a Group Health Plan to a newly adopted dependent child or newborn may be given retroactive effect to the date of birth or date of adoption.

Section 5.18 Special Rule for Health FSAs. If an election change is permitted under the provisions of this Article V, a Participant may change his or her election as follows:

- (a) A Participant may begin to participate in the Health FSA for the balance of the Plan Year; or
- (b) A Participant may increase his/her election amount as long as the election does not exceed the maximum election amount permitted under the Plan; or
- (c) A Participant may decrease the election amount, provided, however, that the amount elected may not be less than the amount Participant has already been reimbursed.

Section 5.19 [Reserved]

Section 5.20 Elections of Former Participants Rehired Within Thirty Days of Termination. If a former Participant is rehired within thirty (30) days after the date on which the Participant's employment relationship with the Employer was terminated, the Participant will be reinstated with the same elections the Participant had before termination unless (a) the Participant would be permitted to make an election change under Article V for a reason other than a change in his/her employment with the Employer or (b) the Plan Year ended on or after the date on which the employment relationship was terminated but before the date of reinstatement.

Section 5.21 Maximum Benefits. The maximum benefits under this Plan are the maximum benefits specified in the Pre-Tax, After-Tax, and Employer Paid Benefits.

ARTICLE VI PLAN ADMINISTRATION

Section 6.01 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. The Plan Administrator shall have the responsibility of ensuring that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the persons entitled to participate in this Plan.

Section 6.02 Powers of the Plan Administrator. The Plan Administrator shall have such powers and duties as it considers necessary or appropriate to discharge its duties under this Plan. The powers of the Plan Administrator shall include, but are not limited to, the following:

- (a) Establish rules and procedures for the purpose of administration of this Plan;
- (b) Require each Participant to supply such information and sign such documents as may be necessary to administer this Plan. In the case of Participant elections, election changes, and other information supplied by the Participant, this power includes requiring elections, election changes, and other information to be submitted using electronic media, subject to and to the extent permitted under applicable IRS and DOL regulations;
- (c) Communicate with Participants through electronic media, subject to and to the extent permitted under applicable IRS and DOL regulations
- (d) Interpret, construe, and carry out the provisions of this Plan and render decisions on the administration of this Plan, including factual and legal determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan;
- (e) Appoint such agents, attorneys, accountants, consultants, Claims Administrators, and any other persons as may be needed for proper administration of this Plan; and
- (f) Take such corrective action as it might consider appropriate in the event that an error in administering this Plan has taken place. For example, if there is a failure to deduct the correct amount of a Participant's election, in such an event, the Plan Administrator has the authority to deduct an overpayment from future compensation payable to the Participant and/or otherwise recover the amount that is owed.

In exercising these powers, the Plan Administrator shall act in its sole discretion, giving due regard for the reason and purpose for which this Plan is established and maintained. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

The Plan Administrator shall have no power to waive, alter, or fail to apply the terms of this Plan.

Section 6.03 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Plan in a nondiscriminatory manner so all persons similarly situated will receive substantially similar treatment.

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ARTICLE VII
HIPAA MEDICAL PRIVACY FOR THE
USD 260 – DERBY PUBLIC SCHOOLS HEALTH FLEXIBLE SPENDING ACCOUNT

PART I
PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Section 7.02 Application of Article VII. The USD 260 – Derby Public Schools Welfare Benefit Plan is a “hybrid entity.” As such, the plan has made a separate hybrid entity designation to define the medical components from the non-medical components of the plan.

This Article shall *only* apply to the USD 260 – Derby Public Schools Health Flexible Spending Account (hereafter referred to as the “Group Health Plan”).

All other benefits provided by the Employer through the USD 260 – Derby Public Schools Welfare Benefit Plan are either (a) not “group health plans” as defined by HIPAA or (b) provided solely through an insurance contract with a health insurance issuer or HMO and do not create or receive protected health information (PHI) other than “summary health information” as defined in 45 C.F.R. Section 164.504(a) or dis/enrollment information.

The Article shall supersede the provisions of the Group Health Plan to the extent those provisions are inconsistent with the provisions of this Article.

PART II
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

Section 7.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose PHI to the Employer.

Section 7.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

- (a) “*Breach*” means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use, or disclosure are excluded from the definition of a “breach:”

- (i) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;
 - (ii) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and
 - (iii) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.
- (b) *"De-identified Health Information"* means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.
- (c) *"Electronic Media"* means:
 - (i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
 - (ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (d) *"Electronic Protected Health Information" ("e-PHI")* is PHI that is transmitted or maintained in electronic media.

- (e) *“Individually Identifiable Health Information”* means information for which each of the following conditions is met:
 - (i) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;
 - (ii) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual;
 - (iii) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (f) *“Plan Administration Functions”* means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.
- (g) *“Protected Health Information (PHI)”* means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.
- (h) *“Security Incident”* (as defined in 45 C.F.R. 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (i) *“Security Rule”* shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.
- (j) *“Summary Health Information”* means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five digit ZIP code.
- (k) *“Unsecured PHI”* means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.05 Enrollment / Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 7.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;
- (b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any Appeals that are filed with respect to claims that are denied in whole or in part;
- (c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;
- (d) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits;
- (e) Detecting fraud or abuse;
- (f) Determining whether charges for services are appropriate or justified;
- (g) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance;
- (h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;
- (i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;
- (j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;

- (k) Reporting corporate finances with to respect to current and projected healthcare costs;
- (l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.06 is subject to the provisions of Section 7.07.

Section 7.07 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.06, the Employer agrees and certifies to the Group Health Plan as required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations to do the following:

- (a) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;
- (b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;
- (c) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;
- (d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and the Department of Health and Human Services ("HHS") may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;
- (e) Effective February 17, 2010, restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;

- (f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his or her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;
- (g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;
- (h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;
- (i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;
- (j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;
- (l) Provide a certification to the Group Health Plan as required by Section 7.08; and
- (m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:
 - (i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;
 - (ii) Ensure that any agents (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and
 - (iii) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section 7.08 Certification by the Sponsor. The Plan (or a health insurance issuer or HMO with respect to the Plan) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 7.07.

By adoption of this Plan document and delivery of a copy of the Plan document to the privacy officer, the Plan Sponsor certifies that (a) the provisions of 45 C.F.R. § 164.504(f)(2)(ii) have been incorporated into the Plan document; and (b) the Plan Sponsor has agreed to the conditions of disclosure set forth in Section 7.07.

PART III ADMINISTRATIVE SAFEGUARDS

Section 7.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.10 Authorized Employees. The following Employee(s) (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to participants:

Director of Finance

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

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ARTICLE VIII GROUP HEALTH PLAN CONTINUATION COVERAGE

This Article VIII applies only to Group Health Plans as that term is defined in Section 2.17. With respect to the Health FSA, however, the specific terms and conditions of continuation coverage as described in this Article are modified by Appendix C, Article C-IV.

Section 8.01 Continuation of Coverage under COBRA. If a “qualified beneficiary” loses (or would lose) coverage under this Plan as a result of a “qualifying event,” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary’s right to continue coverage under this Plan is subject to the following:

- (a) *Qualified Beneficiary.* For purposes of this section, a “qualified beneficiary” means the Participant, the Participant’s Spouse, and the Participant’s dependents, but only if such persons were covered under this Plan on the day before the “qualifying event.” The term “qualified beneficiary” shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.
- (b) *Qualifying Event.* For purposes of this section, a “qualifying event” means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:
 - (i) Termination of the Participant’s employment (other than for “gross misconduct”) or a reduction in the number of hours the Participant normally works.
 - (ii) Death of the Participant.
 - (iii) Divorce or legal separation of the Participant and the Participant’s covered Spouse.
 - (iv) The Participant’s entitlement to Medicare.
 - (v) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.
 - (vi) The Employer files a Chapter 11 bankruptcy (but only as to coverage that is being provided to a retired Participant and his/her Spouse and covered dependents *and* only if the Employer is terminating this Plan while continuing to offer group health coverage to some other group of Employees).
- (c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the plan administrator may establish.

- (d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional two percent (2%) charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional fifty percent (50%) charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the plan administrator may establish.
- (e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:
 - (i) *Termination of Employment or Reduction in Hours.* Eighteen (18) months if coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours.
 - (ii) *Disability Extension.* Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.
 - (iii) *Employer Bankruptcy.* The lifetime of the Participant if:
 - (A) The Employer is providing coverage after the Participant has retired;
 - (B) The Employer files a Chapter 11 bankruptcy;
 - (C) The Employer terminates this Plan (or substantially eliminates coverage under this Plan with respect to a qualified beneficiary within a one year period before or after such bankruptcy proceeding was filed); and
 - (D) The Employer continues to maintain a group health plan for any other group of employees.

In such an event, the surviving Spouse and surviving covered dependents of the Participant shall further be entitled to elect COBRA continuation coverage for an additional thirty-six (36) months following the death of Participant.

- (iv) *Second Qualifying Event.* Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.

- (v) *Any Other Qualifying Event.* Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this subsection (e).
- (f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if any one of the following events occurs:
 - (i) A qualified beneficiary becomes covered under another group health plan;
 - (ii) A required premium is not paid within the applicable deadline (including any applicable grace period);
 - (iii) The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;
 - (iv) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);
 - (v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or
 - (vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage (e.g., a Participant or beneficiary engages in fraudulent activities against the Plan).
- (g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.
- (h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.
- (i) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the Internal Revenue Service and the Department of Labor.

- (j) *Employers Not Required to Offer COBRA Continuation Coverage.* This section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the “small employer” exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering “controlled group” rules and special rules for part-time employees), this Article will apply as described above.

Section 8.02 Retiree Continuation Coverage for Participants with At Least Ten Years of Service with the Employer. If a Participant has at least ten (10) years of service with the Employer at the time of his/her “retirement” from the Employer (as that term is defined below), the Participant may elect to continue coverage under a Group Health Plan (other than a Health FSA) subject to the following conditions:

- (a) *Waiver of COBRA.* The Participant must waive his/her right to elect COBRA continuation coverage pursuant to Section 8.01.
- (b) *Timely Election to Continue Coverage.* The Participant must affirmatively elect, using the procedures prescribed by the Plan Administrator, to continue coverage under a Group Health Plan (other than a Health FSA) no later than 30 days after his/her retirement from employment with the Employer.
- (c) *Retirement.* For purposes of this Section, the term “retirement” means that the Participant has terminated employment and is receiving a retirement or disability benefit for service with the Employer.
- (d) *Termination of Continuation Coverage.* The continuation coverage under this Section shall terminate upon the earliest occurrence of the following events:
- (i) The Participant attains age 65;
 - (ii) The Participant becomes covered, or becomes eligible to be covered, under another employer’s group health plan;
- Note: The reference to “another employer’s group health plan” only refers to an employer of the Participant himself/herself.
- (iii) The Participant fails to make a required premium payment on a timely basis; or
 - (iv) The Employer terminates the Group Health Plan.
- (e) *Coverage of Retiree’s Spouse and/or Dependents.* A Participant who elects to continue coverage under this Section may also elect to cover any Spouse and/or dependent(s) who were covered (through the Participant) under the Group

Health Plan (other than a Health FSA) as of the day of the Participant's retirement from employment with the Employer and who did not elect COBRA continuation coverage pursuant to Section 8.01. The coverage of the Spouse and/or dependent(s) shall terminate upon the earliest occurrence of the following events:

- (i) The Participant's coverage under the Group Health Plan terminates;
 - (ii) The Participant attains age 65;
 - (iii) The Participant fails to make a required premium payment on a timely basis;
 - (iv) The Spouse/dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or
 - (v) The Employer terminates the Group Health Plan.
- (f) *Payment of Premium.* The Participant must pay the entire cost of coverage for this retiree continuation coverage. Although exact premiums will be determined by the Employer, the Employer may also require that the Participant pay an administrative fee of up to twenty-five percent of the cost of the coverage.
- (g) *Construction and Application.* This Section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040.

A retiree who elects coverage pursuant to this Section 8.02 may terminate the coverage at any time, provided, however, such coverage cannot be reinstated once terminated.

Section 8.03 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant's right to continue coverage is subject to the following:

- (a) *Payment of Premium.* The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, Participant must pay the entire cost of coverage plus an additional two percent (2%).
- (b) *Failure to Apply for Reemployment.* Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

- (c) *Reasonable Procedures.* The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this section.
- (d) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute.

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ARTICLE IX
GROUP HEALTH PLAN CLAIMS PROCEDURES
(Does Not Apply to the Health FSA)

Section 9.01 Where to File Claims. Any Claim for benefits which arises under a Group Health Plan shall be filed with the Claims Administrator.

Section 9.02 Persons Who May File Claims. Claims may be filed by the Claimant or by the Claimant's duly authorized representative.

- (a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.
- (b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to Urgent Care Claims.
- (c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claim or Appeal.

Section 9.03 Claims Procedures for Fully-Insured Group Health Plans. Claims made for benefits, and any Appeals from the denial of such Claims, under the fully-insured Group Health Plans, shall be processed in accordance with the claims procedures of the insurer, which are set forth in the Certificate of Coverage. Unless stated otherwise in the policy of insurance, prior to initiating legal action concerning a Claim in any court, state or federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided by the insurer. Failure to exhaust the internal administrative remedies provided by the insurer shall be a bar to any civil action concerning a Claim for benefits under this Plan. Once a Claimant has exhausted his/her administrative remedies, he/she may file a lawsuit challenging the denial of the Claim. Such lawsuit must be commenced no later than 180 days after the Plan issues a final adverse benefit determination or, if external review is sought by the Claimant, no later than 180 days after the Claim is denied in whole or in part on external review.

ARTICLE X
TERMINATION AND AMENDMENT OF THE PLAN

Section 10.01 Termination and Amendment. The Employer may amend or terminate this Plan at any time by written instrument duly adopted by the Employer.

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ARTICLE XI MISCELLANEOUS

Section 11.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 11.02 Employment Not Guaranteed. Nothing contained in this Plan or in any other plan which is a part of the Plan, or any modification or amendment to this Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Plan.

Section 11.03 Funding and Expenses. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Any amounts that may be payable under any of the Pre-Tax Benefits, After-Tax Benefits, and the Employer Paid Benefits shall be paid in accordance with the provisions of the plan document for such plans. All administrative costs of this Plan shall be borne by the Employer.

Section 11.04 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 11.05 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Plan.

Section 11.06 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 11.07 Named Fiduciary. The named fiduciary of this Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Plan.

Section 11.08 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;

- (b) The amounts the Participant has elected to defer into a plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this plan or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

Section 11.09 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 11.10 Nonassignability. The right of any Participant to receive any benefits under this Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 11.11 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Plan on a retroactive basis.

Section 11.12 Reimbursement of Payments Made in Error. The Plan shall have the right to reimbursement from any Participant, covered dependent, or assignee for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the Participant, covered dependent, or assignee was not entitled.

Section 11.13 Return of Premium. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

Section 11.14 Rights to Employer's Assets. No Participant or beneficiary has 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 this Plan, and then only to the extent that the benefits payable under the Component Benefit Plans are payable solely from the assets of the Employer.

Section 11.15 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Plan except to the extent superseded by Federal law.

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IN WITNESS WHEREOF, the Employer adopts this amended and restated Plan, including the HIPAA certification provisions found in Article VII, effective the 1st day of January, 2020.

USD 260 - Derby Public Schools

By:  _____
John Regier, Director of Finance

APPENDIX A MEDICAL PLAN

This Appendix A contains the terms and conditions specific to the USD 260 - Derby Public Schools Medical Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix A, the terms and conditions of the Plan are incorporated into and made applicable to this Medical Plan.

Section A1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.

Section A1.02 Medical Benefits. Benefits under this Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("Blue Cross Blue Shield Group Contract") between Blue Cross Blue Shield ("BCS") and the Employer (Group No. 204150789). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by BCBS. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Medical Plan shall be determined from the BCBS Group Contract. The Participant shall bear fully any and all risk of BCBS's insolvency.

Section A1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the BCBS Group Contract. Under the terms of the Group Contract, BCBS may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant. If money is returned in any form by BCBS, including but not limited to a rebate or proceeds from demutualization, the Plan Administrator shall apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section A1.04 Election to Participate. A Participant who desires to receive medical insurance coverage under this Medical Plan must elect to participate in this Medical Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive medical coverage under this Medical Plan, the Employer will not provide him or her with any medical insurance coverage.

Section A1.05 Payment of Premium. A Participant who has elected to participate in this Medical Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section A1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) ineligible employees as defined in Section 2.12(b) of the Plan, all premiums must be paid through pre-tax salary reductions.

Section A1.06 Continuation of Coverage. An individual who will lose coverage under this Medical Plan may have the right to continue coverage under this Medical Plan as described in Article VIII.

Section A1.07 Children Subject to a NMSN. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Medical Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such NMSN.

Section A1.08 Claims Administration. BCBS will act as Claims Administrator with respect to any claim for benefits under this Medical Plan. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section A1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Medical Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Medical Plan if and to the extent such individual elects continuation of benefits under the rules in Section A1.06.

Section A1.10 Character of Benefits Provided. This Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular medical service may not be eligible for reimbursement under this Medical Plan does not mean that a Participant or other person who is covered under this Medical Plan should not receive that service.

INSERT MEDICAL PLAN POLICY HERE

APPENDIX B DENTAL PLAN

This Appendix B contains the terms and conditions specific to the USD 260 - Derby Public Schools Dental Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix B, the terms and conditions of the Plan are incorporated into and made applicable to this Dental Plan.

Section B1.01 Eligibility / Plan Entry Dates. The eligibility conditions and the Dental Plan entry dates are the same as those for the Plan.

Section B1.02 Dental Benefits. Benefits under this Dental Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("Delta Dental of Kansas Group Contract") between Delta Dental of Kansas ("Delta Dental") and the Employer (Group No. 00186-000-00001-00000). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Delta Dental. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Dental Plan shall be determined from the Delta Dental Group Contract. The Participant shall bear fully any and all risk of Delta Dental's insolvency.

Section B1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Delta Dental Group Contract. Under the terms of the Group Contract, Delta Dental may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section B1.04 Election to Participate. A Participant who desires to receive dental insurance coverage under this Dental Plan must elect to participate in this Dental Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive dental coverage under this Dental Plan, the Employer will not provide him or her with any dental insurance coverage.

Section B1.05 Payment of Premium. A Participant who has elected to participate in this Dental Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section B1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) ineligible employees as defined in Section 2.12(b) of the Plan, all premiums must be paid through pre-tax salary reductions.

Section B1.06 Continuation of Coverage. An individual who will lose coverage under this Dental Plan may have the right to continue coverage under this Dental Plan as described in Article VIII.

Section B1.07 Children Subject to a NMSN. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Dental Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such NMSN.

Section B1.08 Claims Administration. Delta Dental will act as Claims Administrator with respect to any claim for benefits under this Dental Plan. Delta Dental has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section B1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Dental Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Dental Plan if and to the extent such individual elects continuation of benefits under the rules in Section B1.06.

Section B1.10 Character of Benefits Provided. This Dental Plan does not provide dental treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular dental service may not be eligible for reimbursement under this Dental Plan does not mean that a Participant or other person who is covered under this Dental Plan should not receive that service.

DELTA DENTAL OF KANSAS, INC.
A NON-PROFIT SERVICE CORPORATION

SUBSCRIPTION AGREEMENT TO PROVIDE DENTAL BENEFITS

SECTION I - DECLARATIONS

This Subscription Agreement to Provide Dental Benefits ("Agreement") is made and entered into the 14th day of April 2011 by and between U S D #260 - DERBY, hereinafter referred to as "Employer", and DELTA DENTAL OF KANSAS, INC., hereinafter referred to as "DDKS". The initial term of this Agreement shall be from February 1, 2011 to 11:59 PM central time on January 31, 2012, inclusive, and shall renew automatically for subsequent one-year terms, subject to the provisions of Section VII. This Agreement is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communication regarding the Plan.

1.1 CONTRACT NUMBER: 00186-000-00001-00000

1.2 REQUIRED ENROLLMENT AND EMPLOYER PREMIUM CONTRIBUTION:

No less than seventy five percent (75%) of all Eligible Employees must be Subscribers at all times, with a minimum group size of no fewer than two (2) Enrolled Employees. Employer's monthly contribution to the total premium paid for coverage hereunder must at least equal the greater of i) fifty percent (50%) of the total of the individual premiums of all Subscribers, or ii) the same percentage of each Subscriber's premium which is paid by Employer for medical benefits covering the Subscriber. If the enrollment falls below the required percentage of Eligible Employees, or if the minimum group size is not maintained, DDKS may terminate this Agreement upon thirty (30) days notice to the Employer.

1.3 WAITING PERIOD FOR NEW EMPLOYEES:

Each employee who first meets the qualifications of Section 4.2 at a time after the first day of the initial term of this Contract (without regard to whether such employee may have previously been an Eligible Employee pursuant to Section 4.2) shall not be eligible for benefits hereunder until 1st of the month following employment and when the qualification of Section 4.2 would have otherwise been met. Each employee who meets the qualifications under Section 4.2 as of the first day of the initial term of this Contract shall be eligible for benefits immediately upon the Effective Date of this Contract.

1.4 MONTHLY PREMIUM RATES:

Employee:	\$36.74
Employee + Spouse:	\$73.35
Employee + Child(ren):	\$71.93
Family:	\$100.37

Note: Rate cap for 2012 not to exceed 7.0%.
Rate cap for 2013 not to exceed 9.0%.

1.5 SELECTED NETWORK:

The Dental Network for this Agreement is Delta Dental PREMIER.

1.6 SELECTED BENEFITS, MAXIMUMS, DEDUCTIBLES AND CO-INSURANCE PERCENTAGE PAID BY DDKS:

A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of this Plan or would otherwise be reimbursable, in whole or in part, except for the application of a deductible, co-insurance payment, waiting period, frequency limitation, annual or lifetime benefit maximum, or other limitation contained in the Plan. For a Covered Service benefited by DDKS through payment, DDKS will pay the lesser of i) the percentage of the fee actually charged for a Covered Service which is indicated in the Summary of Dental Plan Benefits below, or ii) in the amount which is otherwise paid in accordance with other provisions of the Plan.

Summary of Dental Plan Benefits

Group # 00186-000-00001-00000

Maximum Benefit Per Person

The Maximum Benefit for all Covered Services for each Enrollee in any one Calendar Year is One Thousand Five Hundred Dollars (\$1500.00).

Deductible Limitations

Coverage for oral evaluations, x-rays, prophylaxis, fluoride treatments, space maintainers and sealants is not subject to the Deductible. However, the Deductible shall apply during each Calendar Year to all other Covered Services which are provided to each Enrollee. After Subscriber and his/her Eligible Dependents who are Enrollees have, in any Calendar Year, each paid either the individual Deductible of Twenty Five Dollars (\$25.00), or have cumulatively paid charges for Covered Services in the amount of Seventy Five Dollars (\$75.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that Calendar Year.

% paid by DDKS	Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)	
Premier Network 100%	I. DIAGNOSTIC: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <u>Oral evaluations</u> – once each six (6) months. <u>Diagnostic x-rays</u> – bitewings once each six (6) months for dependents under age eighteen (18) and once each twelve (12) months for adults age eighteen (18) and over. <u>Full mouth x-rays or panoramic x-rays</u> – once (1) each five (5) years.
100%	II. PREVENTIVE: Provides for the following: <u>Prophylaxis</u> (Cleanings) – once each six (6) months. <u>Topical Fluoride</u> – once each six (6) months for dependent children under age nineteen (19). <u>Space Maintainers</u> for dependent children under age fourteen (14) and only for premature loss of primary molars. <u>Sealants</u> – once (1) per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Subject to Deductible)	
80%	III. ANCILLARY: Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
80%	IV. ORAL SURGERY: Provides for extractions and other oral surgery including pre and post-operative care.
80%	V. REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations, composite (white) resin restorations on anterior (front) teeth; and stainless steel crowns for dependents under age twelve (12).
80%	VI. ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.
80%	VII. PERIODONTICS: a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted towards the limitation for prophylaxis.
80%	b. Surgical periodontal procedures.

Summary of Dental Plan Benefits

(Continued)

Group # 00186-000-00001-00000

Payment of Claims

Before paying claims, DDKS may require reasonable evidence of the payment of Deductibles.

Eligible Dependent Ages

Dependents are eligible for coverage to age 26.

% paid by DDKS	Examples of Covered Services
MAJOR (Subject to Deductible)	
Premier Network 50%	VIII. SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	IX. PROSTHODONTICS: Includes bridges, partial and complete dentures, including repairs and adjustments.
ORTHODONTICS (Subject to Deductible)	
None	X. ORTHODONTICS: Orthodontic appliances and treatment.

1.7 ADDITIONAL PLAN INFORMATION:

This Plan is the secondary plan for dental procedures that are covered under the enrollee's health plan.

NOTE: SEE ADDITIONAL EXCLUSIONS AND LIMITATIONS IN SECTION II.

SECTION II - EXCLUSIONS AND LIMITATIONS

2.1 Unless Sections 1.6 and/or 1.7 Specifically Provide For Coverage, The Following Dental Benefits And Services Are Excluded:

- a. Coverage for any patient who has been, but no longer is, an Enrollee.
- b. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.
- c. Benefits or services which are determined by DDKS to be for Cosmetic purposes.
- d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.
- e. Prescription drugs, premedications and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs; charges for failure to keep a scheduled visit; and charges for completion of forms.
- f. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for cosmetic purposes; for splinting or equilibration.
- g. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.
- h. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.
- i. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of this Agreement.
- j. Crowns and endodontic treatment in conjunction with an overdenture.
- k. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7.
- l. Replacement of lost or stolen dentures or charges for duplicate dentures.
- m. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in Section 1.6 and/or Section 1.7.
- n. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.
- o. Any benefit, procedure or service, a motivating purpose for which is to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.
- p. Dental benefits and services which are not completed.
- q. Treatment rendered outside of the United States or Canada.
- r. Benefits or services for control of harmful habits.
- s. Treatment to correct congenital or developmental malformations.

- t. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in Section 1.7. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.
- u. Individual crowns unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7.
- v. Procedures for dental implants and associated services, unless these are specified as Covered Services in Section 1.6 and/or Section 1.7.
- w. Diagnosis or treatment of temporomandibular joint dysfunction, unless these are specified as Covered Services in Section 1.6 and/or Section 1.7.

2.2 Dental Benefits and Services are Limited as Follows, unless Section 1.6 or Section 1.7 specifies other limitations. Typically, when dental benefits and services are limited under the Plan, any amounts not benefited by DDKS due to the limitation are the responsibility of the Enrollee, up to the amount of the Maximum Plan Allowance (MPA).

- a. If a more expensive Covered Service is provided than DDKS determines to be the least costly professionally accepted treatment, DDKS will pay the applicable benefit for the Covered Service which is needed to achieve reasonable functionality.
- b. Some Covered Services may be subject to specific age and frequency limitations. These limitations are generally identified in Section 1.6 and/or Section 1.7.
- c. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are benefited by DDKS under the Plan and then only if specifically included as a Covered Service in Section 1.6 and/or Section 1.7.
- d. Prophylaxis, periodontal maintenance and oral evaluations may be subject to specific time and frequency limitations. Such limitations are identified in Section 1.6 and/or Section 1.7. Bitewing x-rays may be subject to specific age, time and frequency limitations. Such limitations are identified in Section 1.6 and/or Section 1.7.
- e. Full mouth and panoramic x-rays may be subject to specific time and frequency limitations. Such limitations are identified in Section 1.6 and/or Section 1.7. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit.
- f. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.
- g. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations.
- h. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.
- i. Claims not submitted to DDKS within six (6) months of the date that the Covered Service was provided will not qualify as a Covered Service unless it was not reasonably possible to submit the claim within such time and provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.
- j. Sealants are limited to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact. Coverage for sealants is limited to one (1) per lifetime per permanent molar unless Section 1.6 and/or Section 1.7 allows for other frequency limitations.
- k. Inlays will automatically receive benefits equal to the corresponding surface of a filling.
- l. Individual crowns are not a Covered Service unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. If a Covered Service:
 - (1) Individual crowns on the same tooth are limited to only once (1) in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Enrollee

whether or not the Agreement was then effective. If a crown is placed on a tooth which has had a restoration in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

- (2) Porcelain crowns, porcelain fused to metal; or resin processed to metal type crowns are not benefited by DDKS for any person under twelve (12) years of age due to age limitation.
 - (3) Recementation of a crown is limited to only once (1) in a lifetime.
 - (4) Repairs per crown are limited to two (2) in a twelve (12) month period.
 - (5) Stainless steel crowns are limited to once (1) in a twenty-four (24) month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection 2.2 (1) will apply.
 - (6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.
- m. Prosthetic appliances are not a Covered Service unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. If a Covered Service, the following limitations apply unless Section 1.6 and/or Section 1.7 state different limitations:
- (1) Not more than one (1) full upper and one (1) full lower denture shall be constructed under the Agreement in any five (5) year period for any Enrollee. Said time period is to be measured from the date the denture was last supplied to the Enrollee whether or not the Agreement was then effective.
 - (2) A removable prosthetic or fixed prosthetic may not be provided under the Agreement for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the date the denture or bridge was last supplied to the Enrollee whether or not the Agreement was then effective.
 - (3) Denture relines and rebase is limited to only once (1) in any thirty-six (36) month period for Enrollee.
 - (4) Denture adjustments are limited to only two (2) times in any twelve (12) month period for an Enrollee.
 - (5) Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.
 - (6) Recementation of a bridge is limited to only once (1) in a lifetime.
 - (7) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.
 - (8) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.
 - (9) Tissue conditioning is limited to no more than two (2) per arch each thirty-six (36) months.
- n. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period.
- o. Periodontic procedures are not Covered Service unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation.
- p. Composite (white) fillings are covered on anterior (front) teeth. The Plan will provide benefits in an amount up to the Maximum Plan Allowance (MPA) for an equal surface amalgam (silver) filling on posterior (back) teeth.

- q. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of ninety (90) minutes, per episode.
- r. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in Section 1.6 and/or Section 1.7.

2.3 Certain Dental Benefits and Services Provided Are Disallowed under the Plan. When dental benefits or services are disallowed, the fees associated with those items are neither benefited by DDKS nor collectable from the Enrollee by a Participating Dentist. Disallowed services will be so indicated on the applicable Enrollee's Explanation of Benefits.

SECTION III – DEFINITIONS

For the purpose of this Agreement, the following definitions shall apply:

- 3.1 “Agreement” means this agreement between DDKS and Employer, including the Group Application, the attached appendices, endorsements and riders, if any. This Agreement constitutes the entire agreement between the parties.
- 3.2 “Benefit Booklet” means the written summary of certain features of the Plan.
- 3.3 “Child” means, in addition to the Subscriber’s own or lawfully adopted unmarried child or children, any unmarried step-child of the Subscriber residing with the Subscriber in a regular parent-child relationship so long as said child is not eligible to enroll in an “eligible employer-sponsored health plan” as defined by federal law. The term “Child” also includes any unmarried person placed with the Subscriber for adoption if such child was placed in the Subscriber’s home by a child placement agency as defined by Kansas law, and any unmarried child of the Subscriber who is recognized as an alternate recipient under a qualified medical child support order. A child is eligible for coverage under the Plan if the child meets the age requirements as set forth in Section 1.6.

In addition, a Child includes an unmarried disabled Child who is: i) incapable of earning his or her own living because of mental or physical disability, and ii) principally dependent upon the Subscriber for support at the time the Child would otherwise cease to be eligible for coverage by the Plan because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty-one (31) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

- 3.4 “Continuation Coverage” means the coverage provided under this Agreement pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended (“Code”). All of the requirements, definitions and specifications of said Section 4980B of the Code which are necessary in order for this Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.
- 3.5 “Contract Year” means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.
- 3.6 “Calendar Year” means the twelve (12) month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.
- 3.7 “Cosmetic” means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are “Cosmetic” shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan unless a Cosmetic service is specified as a Covered Service in Section 1.6 and/or Section 1.7.
- 3.8 “Covered Services” means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of this Agreement.
- 3.9 “DDKS” means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Association member company which has agreed to provide to Enrollees the benefits described in this Agreement, or both, as applicable.
- 3.10 “Deductible” means the amount specified in the Summary of Dental Benefits in Section 1.6 which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.
- 3.11 “Dental Network” means one of the following networks as identified in Section 1.5:
 - a.1. **“Delta Dental Premier”:** The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS’ Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-Participating Dentists are not considered Delta Dental Premier Providers, and are paid according to DDKS’ Non-Participating Dentist Maximum Plan Allowance.
 - 2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist

who does not participate in the Delta Dental Premier network, the Enrollee is responsible for all treatment costs incurred.

- b.1. **“Delta Dental PPO”:** The Delta Dental PPO network is a subset of DDKS Participating Dentists who agree contractually to participate in the Delta Dental PPO network as part of a discounted fee-for-service plan. Delta Dental PPO providers sign a supplemental agreement and are paid according to a Maximum Plan Allowance for PPO Dentists as defined below. Delta Dental PPO Dentists are paid at the in-network co-insurance percentages in Section 1.6 and/or Section 1.7, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in Section 1.6 and/or Section 1.7.
2. If Delta Dental PPO is the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.
3. If Delta Dental PPO is a Passive Network, then co-insurance levels for Delta Dental PPO and Delta Dental Premier are the same and Enrollees can use any Participating Dentist, as shown in Section 1.6 and/or Section 1.7.

3.12 “Dentist” means any duly licensed person entitled to practice dentistry at the time and in the place the dental services are performed.

3.13 “Effective Date” means the first day of the initial term of this Agreement.

3.14 “Eligible Dependent” means i) the spouse of a Subscriber, ii) a Child of a Subscriber who satisfies the requirements of Section 3.3, and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

3.15 “Eligible Employee” means any person who meets the conditions of eligibility outlined in Section IV of this Agreement, and any person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

3.16 “Employer” means the person(s) and/or entity(ies) named above which has hereby contracted with DDKS to provide the Plan described in this Agreement, and such members of the Employer’s controlled or affiliated group which are specifically listed in the Group Application.

3.17 “Enrollee” means a person, whether an Eligible Employee or Eligible Dependent, who is i) eligible to be covered by the Plan, ii) validly enrolled in the Plan, and iii) for whom the appropriate premium is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee’s name, enrollment information and the required premium are furnished to DDKS by Employer. However, in the case of an Enrollee in Continuation Coverage, such person shall be deemed to have enrolled when DDKS is timely furnished by the Enrollee with the applicable enrollment form and premium.

3.18 “Group Application” means the formal, written request for coverage by the Employer to DDKS. The Group Application includes all data and related information which is required to be provided to DDKS from time to time.

3.19 “Maximum Benefit” means the maximum benefit provided for Covered Services (and Orthodontic Services if specifically included as a Covered Service) which is set forth in the Summary of Dental Plan Benefits.

3.20 “Maximum Plan Allowance” means the lesser of the following:

- a. In the case of a Participating Delta Dental Premier Dentist:
 - i) the fee submitted by the Participating Dentist for the Covered Service, or
 - ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.
- b. In the case of a Delta Dental PPO Dentist:
 - i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or
 - ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.
- c. In the case of a Non-Participating Dentist:
 - i) the fee submitted by the Dentist for the Covered Service,
 - ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or

iii) if this Plan utilizes an Exclusive Network, no benefits are provided.

- 3.21** "Orthodontic Services" means appliances and treatments, interceptive and corrective, whose purpose is to correct abnormally aligned or positioned teeth. X-rays, extractions and other dental services provided as part of the treatment of abnormally aligned or positioned teeth are considered "Orthodontic Services."
- 3.22** "Participating Dentist" means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentist agree to render services in accordance with the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.
- 3.23** "Plan" means the dental benefits arrangement which is offered and administered pursuant to the terms of this Agreement.
- 3.24** "Subscriber" means an Eligible Employee who has enrolled in the Plan during annual open enrollment or other enrollment period established by the Employer following the employee's hire date or the occurrence of a qualifying event, as described in Section 4.2(c), and timely payment of the required premium has been made.

SECTION IV - ELIGIBILITY

4.1 ELIGIBLE EMPLOYEE:

To qualify as an Eligible Employee, an individual must meet the Waiting Period in Section 1.3 and one (1) of the following requirements:

- a. Be a full-time employee who is:
 1. actively employed to work for Employer a regularly scheduled minimum thirty (30) hour week;
 2. on paid sick leave from such active employment;
 3. on any other approved leave of absence from such active employment; or
- b. Be a member in good standing of an organization, association or union which is the Employer, as determined under the rules of such organization, association or union.
- c. Be a self-employed person who is actively engaged in a trade or business with at least one other self-employed person or employee, all as determined by DDKS.

4.2 COMMENCEMENT OF COVERAGE FOR EMPLOYEE:

- b. With respect to a person who is an Eligible Employee on the Effective Date, coverage hereunder shall begin upon such person becoming a Subscriber.
- b. With respect to a person who is not an Eligible Employee on the Effective Date, then coverage hereunder shall begin the first day of the month following the later of i) such person becoming a Subscriber, or ii) the effective date associated with the Employer designated enrollment period.
- c. With respect to a person who is an Eligible Employee who experiences a "qualifying event," such Eligible Employee may make a new election within thirty-one (31) days of the qualifying event that corresponds to the gain or loss of eligibility and/or coverage under the Plan, or a plan of the Spouse's or Dependent's employer, that was caused by the occurrence of such qualifying event. Changes in coverage will become effective on the first day of the month coincident with or following the later of: i) the month in which the Eligible Employee becomes a Subscriber, ii) the effective date specified in the election, or iii) the submission of any required enrollment information and the payment of any required premium to DDKS. For purposes of this Section IV, a "qualifying event" is any of the events described below:
 - (1) Legal Marital Status. A change in an Eligible Employee's legal marital status such as marriage or divorce.
 - (2) Number of Dependents. A change in the Eligible Employee's number of Dependents, including the birth and/or adoption of a child.
 - (3) Gaining or Losing Coverage Eligibility Under Another Employer's Plan. A change in coverage or eligibility status in which an Eligible Employee or Eligible Dependent gains or loses eligibility for coverage under a plan that is available to the Eligible Dependent. In such event an Eligible Employee may elect to cease or become covered under the Dependent's employer's plan.

4.3 NO COVERAGE AS BOTH EMPLOYEE AND DEPENDENT:

No person may be insured both as an Eligible Employee and as an Eligible Dependent, and no person will be considered as an Eligible Dependent of more than one (1) Employee. Eligible Dependents do not include another Employee of the Employer who is insured under any employer-sponsored program providing dental expense coverage. A Child who may be otherwise eligible as a dependent under more than one (1) dental plan sponsored by the Employer, shall be covered under the plan of the employee as determined by Section 6.1 of this Agreement.

4.4 COMMENCEMENT OF COVERAGE FOR DEPENDENT:

- a. With respect to a person who is an Eligible Dependent on the Effective Date, coverage hereunder shall begin for such Eligible Dependent upon the later of i) the first day that the coverage commences for the Subscriber, or ii) the date such person satisfies the requirements to become an Enrollee.
- b. With respect to a person who is an Eligible Dependant who is not an Enrollee on the Effective Date, then coverage hereunder shall begin upon the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee, or iii) upon the effective date associated with such open enrollment period.
- c. With respect to a person who becomes an Eligible Dependent and therefore qualifies for coverage as a result of a qualifying event, then coverage hereunder shall begin upon the first day of the month coincident with or following the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee.

4.5 TERMINATION OF BENEFITS:

- a. If, at any time, a Subscriber fails to satisfy all of the requirements of this Agreement, coverage under this Agreement shall terminate for such Subscriber, and each dependent of such Subscriber, in the following manner:
 - 1) If the Subscriber qualifies for, timely elects and timely pays for Continuation Coverage, then the Subscriber shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter coverage shall terminate;
 - 2) If the Subscriber fails to qualify for, timely elect or timely pay for Continuation Coverage, then coverage shall terminate at the end of the premium period in which the Subscriber first ceases to satisfy such requirements.
- b. If, at any time, an Enrollee who is not the Subscriber ceases to qualify as Eligible Dependent, coverage under this Agreement shall terminate:
 - 1) If the Enrollee qualifies for, timely elects, and timely pays for Continuation Coverage, then the Enrollee shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter the coverage shall terminate;
 - 2) If the Enrollee fails to qualify for, timely elect, or timely pay for Continuation Coverage, then coverage shall terminate at the end of premium period in which the Subscriber upon whom such person is dependent ceases to constitute a Subscriber, or at the time such dependent ceases to qualify as an Eligible Dependent, whichever occurs first.
- c. At termination of coverage under this Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

SECTION V - AGREEMENTS

5.1 EMPLOYER AGREES:

Throughout the term of this Agreement, Employer agrees as follows:

- a. At the time of the execution of this Agreement, to furnish DDKS with accurate initial enrollment information regarding all Enrollees, including those on Continuation Coverage, together with the Social Security number or other identification number of all such Enrollees. Employer also agrees to furnish DDKS with an accurate list of all Subscriber. Thereafter, Employer agrees to furnish monthly to DDKS an accurate accounting of all changes to such initial list of Subscribers and Enrollees.

- b. To timely remit to DDKS all applicable premiums as follows:

Initial premium — on or before the tenth (10) day of the month in which the Effective Date occurs.

Subsequent premiums — on or before the tenth (10) day of each month subsequent to the Effective Date.

Continuation Coverage premiums — on or before the first (1) day of each month commencing with the Effective Date.

Upon discovery of any Employer clerical errors or delays regarding changes in enrollment data, premium amounts and enrollment data may be adjusted by DDKS for all affected months since the Effective Date. However, DDKS shall not be required to refund any amount which is based upon more than two (2) months of retroactive information, and in no event shall such refund exceed the amount of premium attributable to more than ten percent (10%) of the total number of Employer's last reported Enrollees.

- c. To provide each Subscriber with a Benefits Booklet.
- d. To permit and to encourage the professional relationship between a Dentist and Enrollee to be maintained without interference.
- e. To encourage Enrollees to notify their Dentist at the time of their first appointment that they are covered by this Agreement.
- f. To permit DDKS, its auditors or other authorized representatives, on reasonable advance written notice, to inspect the records of the Employer in order to verify the accuracy of all information provided by Employer to DDKS.
- g. To provide DDKS with such other information as it shall request in connection with this Agreement.
- h. At the time of the execution of this Agreement, and at all times while this Agreement is in effect, Employer represents and warrants that its Employees and Enrollees constitute a "group" for purpose of state insurance laws. Employer agrees that DDKS has discretion to determine if such requirements are met and will produce information requested by DDKS to substantiate compliance with this requirement. Employer acknowledges no benefits will be provided under this Agreement if such persons do not constitute a "group."

5.2 DDKS AGREES:

Throughout the term of this Agreement, DDKS agrees as follows:

- a. Prior to making payment for Covered Services, to require the Dentist or Subscriber, as the case may be, to timely submit a claim which satisfies the claims procedures of DDKS.
- b. To make no payment for any Covered Service rendered to a person who is not an Enrollee at the time such service is rendered, except as herein provided under the "Termination of Benefits" Section of this Agreement.
- c. To make payment to a Participating Dentist, Non-Participating Dentist, or Subscriber, as the case may be, for each Covered Service based upon the applicable terms of this Agreement.

SECTION VI - GENERAL PROVISIONS

6.1 NON-DUPLICATION OF BENEFITS:

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term "plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed one hundred percent (100%) of the total allowable expense.

A. DEFINITIONS.

(1) A "plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(a) The term "plan" includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of two hundred dollars (\$200) per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident type coverage; and Medicare or other governmental benefits, as permitted by law.

(b) The term "plan" does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of two hundred dollars (\$200) or less per day; medical benefits under group or individual automobile contracts; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.

(2) The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

(3) "Allowable expense" means a dental care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(a) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(b) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.

- (4) "Claim determination period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.
- (5) "Closed panel plan" is a plan that provides dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- (6) "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

B. ORDER OF BENEFIT DETERMINATION RULES.

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

- (1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- (2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with this Section 6.1 is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- (3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- (4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - (a) The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
 - (b) The order of benefits when a child is covered by more than one (1) plan is:
 - 1. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - a. The parents are married;
 - b. The parents are not separated (whether or not they ever have been married); or
 - c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - 2. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - a. The plan of the custodial parent;
 - b. The plan of the spouse of the custodial parent;
 - c. The plan of the noncustodial parent; and then
 - d. The plan of the spouse of the noncustodial parent.
- (c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under Section 6.1 C.(4)(a) hereof.
- (d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (e) The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- (f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan may be primary if stated in Section 1.7.
- (g) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

C. EFFECT ON THE BENEFITS OF THIS PLAN.

- (1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
 - (a) Determine its obligation to pay or provide benefits under its contract;
 - (b) Determine whether a benefit reserve has been recorded for the covered person; and
 - (c) Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero (0). A new benefit reserve must be created for each new claim determination period.
- (2) If a covered person is enrolled in two (2) or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one (1) closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts about coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. DDKS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. DDKS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give DDKS any facts it needs to apply those rules and determine benefits payable.

E. FACILITY OF PAYMENT.

A payment made under another plan may include an amount that should have been paid under this plan. If it does, DDKS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. DDKS will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2 DENTIST CONDUCT:

DDKS may refuse to pay for any Covered Services which are provided in a matter that is inconsistent with the generally accepted applicable standards of dentistry.

6.3 DDKS LIABILITY:

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to employees, Enrollees, Dentists, dental assistants, dental hygienists, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, DDKS shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

6.4 ENDORSEMENTS:

Nothing contained in any endorsement shall affect any of the conditions, provisions or limitations of the Agreement except to the extent expressly provided in the endorsement. Otherwise, all conditions, provisions and limitations of this Agreement shall apply to any endorsement.

6.5 PUBLICATION OF THIS AGREEMENT:

No material shall be published or distributed by Employer or otherwise, interpreting, relating to or concerning this Agreement unless such material has been approved by DDKS in advance of such publication or distribution.

6.6 RIGHT TO INFORMATION:

As a condition precedent to the approval of claims hereunder, DDKS, shall be entitled to receive from any attending or examining Dentist, or from hospitals or clinics in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, and/or treatment rendered to, an Enrollee. DDKS, at its own expense, shall have the right to cause any Enrollee to be examined when and so often as DDKS reasonably deems necessary during the pendency of a claim under this Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under this Agreement constitutes the Enrollee's (and the related Subscriber's, if applicable) automatic and irrevocable consent to the release to DDKS of any and all of the information and records before described, and a full waiver by that

Enrollee that any such information and records that otherwise is privileged. Further, by providing Covered Services to an Enrollee, a Dentist or other service provider consents to, upon request, provide such information and records to DDKS as DDKS requests.

6.7 CONFIDENTIALITY:

DDKS agrees that it has "protected health information" ("Information") as defined in 45 C.F.R. Part 160-164 (the HIPAA Privacy Rule). DDKS agrees that it will:

- 1) not use or further disclose the Information other than as permitted or required by this Agreement or as required by law;
- 2) use appropriate safeguards to prevent use or disclosure of Information other than as provided for by this Agreement;
- 3) report to the Enrollee any use or disclosure of the Information not provided for by this Agreement of which DDKS becomes aware;
- 4) ensure that any agents, including a subcontractor to whom DDKS provides Information received from or created by the business associate on behalf of the Enrollee, agree to the same restrictions and conditions that apply to the business partner with respect to such Information;
- 5) make available Information in accordance with 45 C.F.R. 164.520;
- 6) make available Information for amendment and incorporate any amendments to Information in accordance with 45 C.F.R. 164.526;
- 7) make available the Information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;
- 8) make its internal practices, books, and records related to the use and disclosure of Information received from, or created or received by, the business associate on behalf of the Enrollee available to the United States Secretary of Health and Human Services for the purpose of determining the compliance with 45 C.F.R. Part 160-164; and,
- 9) at the termination of this Agreement, if feasible, return or destroy all Information received from or created or received by, the business associate on behalf of the Enrollee, that the business partner still maintains in any form and retain no copies of such Information; or, if such return or destruction is not feasible, extend the protections of the this Agreement to the Information and limit further uses and disclosures to those purposes that make the return or destruction of the Information infeasible.

6.8 MISREPRESENTATIONS:

No statements made by the Employer, or any other person, shall be deemed a warranty or shall be used in defense of a claim or in any other dispute under this Agreement, unless it is contained in a written instrument, a copy of which has been agreed to in writing by Employer and DDKS.

6.9 POLICY CHANGES:

No agent or representative has authority to change this Agreement or waive any of its provisions. No change in this Agreement shall be valid unless approved by an executive officer of DDKS and evidenced by endorsement hereon.

6.10 LEGAL ACTIONS:

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of this Agreement. Further, and in all events, any action of any kind by any person who is subject to this Agreement must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.

6.11 GOVERNING STATUTES:

Any provision of this Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

6.12 GOVERNING LAW:

Except to the extent preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the laws of the State of Kansas (irrespective of choice of law principles) shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret this Agreement (including but not limited to any mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises) shall be commenced and maintained in a location mutually agreeable by the parties to the dispute. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue in the court mutually agreed to by the parties for such purpose and agree not to seek transfer or removal of any action commenced in connection with this Agreement.

6.13 SEVERABILITY:

If any part of this Agreement is determined to be invalid, unenforceable, or contrary to law or professional ethics, that part shall be reformed, if possible to conform to applicable law and ethics. If reformation is not possible, that part shall be deleted, and the other parts of the Agreement shall remain fully effective.

6.14 ASSIGNMENT:

Employer may not assign its interest in this Agreement without the prior written consent of DDKS.

6.15 NOTICE:

Any notice required or desired to be given under this Agreement shall be deemed to have been given if delivered personally to hereinafter named designee of Employer or DDKS, or sent by first-class United States Postal mail as provided herein. Any such notice shall be effective upon receipt of said notice unless an alternate date is specified. Employer shall have the right to designate a different address or agent for the receipt of notice by providing written notice of such designation in the manner set forth herein. Notices to the Employer shall be in writing and, shall be sent to the person named in the Group Application at the address stated therein. Notices to DDKS shall be in writing and sent to:

Compliance Officer
Delta Dental of Kansas, Inc.
PO Box 789769
Wichita, KS 67278-9769

6.16 PREDETERMINATION OF BENEFITS:

Treatment plans that involve Covered Services which include prosthodontic services, orthodontic services, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics, and oral surgery except for simple extraction of a single tooth, should be submitted to DDKS for predetermination of benefits. Failure to do so may result in a loss of benefits if, in the professional judgment of DDKS, such treatment is not necessary or a lesser procedure could have restored the tooth or dental arch to a reasonable degree of functionality. A predetermination of benefits does not obligate DDKS to provide any benefits associated therewith if the Enrollee is no longer eligible to receive such benefits at the time the Covered Services are performed. A predetermination of benefits is only effective with respect to Covered Services which commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist. Otherwise a new predetermination of benefits must be sought.

6.17 BENEFITS BOOKLET:

DDKS shall prepare a Benefits Booklet which shall be approved by the Commissioner of Insurance for the State of Kansas. The Benefits Booklet shall summarize certain features of the Plan's coverage, including the eligibility rules, benefits and, methods of securing claims payments.

6.18 EMERGENCY TREATMENT:

Each individual dental office has its own emergency treatment protocol and Enrollees should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours. Hospital or medical service emergency room expenses are not covered benefits under this Agreement.

6.19 INQUIRIES/APPEALS:

Dentists and Enrollees are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the DDKS Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511 or from outside of the Wichita area, 1-800-234-3375.

Enrollees who have inquiries or an appeal regarding the Agreement are encouraged to write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769. Written inquiries are best submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Subscriber's name and birth date. If the Enrollee is not the Subscriber, the Enrollee's name and birth date must also be included.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

When appropriate, an evaluation will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested for a full and fair review. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Enrollees will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS' receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter.

6.20 REGIONAL CONSULTANTS:

The review of a claim form and x-rays may not be sufficient to appropriately resolve a matter in all cases. Accordingly, in some cases DDKS may rely on its regional dental consultants to examine patients clinically. When appropriate, examinations may also be conducted at the request of the Enrollee, a treating Dentist, or for other reasons determined by DDKS.

6.21 NOTICE OF CLAIM:

Written notice of claim must be given to DDKS within twenty (20) days after the occurrence or commencement of any claim/loss covered by the Agreement, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Enrollee or the beneficiary to the Enrollee to DDKS at 1619 N. Waterfront Parkway, Wichita, KS 67206, or to any authorized agent of DDKS, with information sufficient to identify the Enrollee, shall be deemed notice to DDKS.

6.22 CLAIM FORMS:

DDKS, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time frame fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

6.23 PROOFS OF LOSS:

Written proofs of loss/claims must be submitted to DDKS at its office within six (6) months of the date that the Covered Service was provided. But, failure to submit a claim within six (6) months of the date that the Covered Service provided will not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time, provided that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

6.24 TIME OF PAYMENT OF CLAIMS:

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

6.25 MISCELLANEOUS:

- a. **Waiver of Breach.** The waiver of any breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach.
- b. **Captions.** The paragraph headings are for convenience only, and shall be disregarded in interpreting this Agreement.
- c. **Authorized to Enter into Agreement.** Both Employer and DDKS represent and warrant they are authorized to enter into this Agreement.
- d. **No Presumptions Based on Drafter.** No provisions of this Agreement shall be interpreted for or against any party hereto on the basis that such party was the draftsman of such provision, and no presumption or burden of proof shall arise disfavoring any party by virtue of the authorship of any of the provisions of this Agreement.

SECTION VII - TERM AND TERMINATION

7.1 This Agreement shall remain in full force and effect for the term specified in Section I, but the Agreement may be terminated by DDKS, if:

- a. The Employer fails for longer than thirty (30) days from the due date to make a required payment; or
- b. The Employer permits "voluntary enrollment" of Enrollees, or otherwise fails to satisfy the requirements of Section 1.2, except as specified in the Declarations Section or as specified in a policy endorsement; or
- c. The Employer voluntarily wishes to cancel this Agreement prior to renewal date and provides Delta Dental of Kansas, Inc. with thirty (30) days written notice of intent to terminate; or
- a. The Employer refuses to allow DDKS (by its auditors or other authorized representatives) to inspect Employer's records in order to verify the accuracy of the Eligible Employee and/or enrollment information, or Employer otherwise defaults, by an act of either omission or commission, in the performance by it of any duties or obligations hereunder; or
- b. The Employer breaches any representation or warranty, or does not otherwise fulfill its responsibilities, under this Agreement; or
- c. The premium rate for this Agreement is determined by using the actuarial assumption that the Agreement will remain in full force and effect for a minimum period equal to the initial term hereof. If, during the initial term, the Agreement is terminated for any one (1) or more of the preceding reasons, the Employer shall nevertheless owe DDKS, in addition to whatever premium or premiums have already been paid and in addition to any accrued but unpaid premiums, a minimum termination premium that shall be calculated as follows:

$$\frac{\text{Total of premiums paid plus premiums accrued but unpaid, if any, by Employer for the months prior to termination.}}{\text{Number of months for which such premiums were paid or accrued and owed.}} \times \frac{\text{Number of months remaining in the initial term after termination.}}{\text{Amount of minimum termination premium.}} =$$

7.2 This Agreement may be terminated by DDKS by delivering to Employer a notice of intention to terminate if such notice is delivered in writing to Employer at least thirty (30) days prior to such termination, except that if Employer defaults in the making of premium payments, termination of the Agreement shall become effective on the date of the expiration of the period for which the last monthly premium rate was paid. In no event will DDKS be required by this Agreement to provide any benefits for any period for which the Employer has not made the premium payments in advance of the incurrence of the benefits.

7.3 If Employer defaults in making any payments due hereunder to DDKS, the subsequent acceptance by DDKS of such payments shall reinstate this Agreement, but such reinstatement shall provide coverage under the Plan only with respect to Covered Services which are first provided more than ten (10) days after the date of such reinstatement.

7.4 At least thirty (30) days prior to the expiration of the initial term of this Agreement, DDKS will send Employer or Employer's designated agent written notification of renewal, setting forth adjustments to Contract terms including premium rates. If Employer does not wish to renew the Agreement, it must provide DDKS with written notification of the same. If Employer makes payment to DDKS under the adjusted premium rates, or otherwise takes action which indicates continued performance under the Agreement after the expiration date of the term of this Agreement, the Agreement will be automatically renewed for a subsequent one year term upon the same terms and conditions as are herein set forth, modified by those adjustments set forth in the written notification of renewal. If, after the expiration of the initial term of the Agreement, Employer makes payment to DDKS which is not consistent with the adjusted premium rates set forth in the written notification of renewal, then DDKS may at its sole option either consider this Agreement to have been renewed under the adjustment terms set forth in the written notification and bill Employer for the remainder of the premium rate due, or consider this Agreement to have not been renewed and return the premium to Employer.

SECTION VIII – GUARANTEE OF SERVICE EXCELLENCE

8.1 During the term of this Agreement, DDKS shall extend to Employer the service guarantees described in Section 8.6 of this Agreement (“Service Guarantees”).

8.2 In order to qualify for a refund or credit under Section 8.6, the following procedures must be followed:

- (a) DDKS must receive the Employer’s notification, in writing (as described in “b” below) of a service failure within ninety (90) calendar days from the date on which such failure occurred. Within the same ninety (90)-day period, DDKS must also receive payment for all invoiced subscription or premium charges for such period. Claims under the Service Guarantees shall not be deducted from subscription or premium charges or administrative fees paid by the Employer.
- (b) If notification is made by telephone, a written claim containing all relevant information must still be filed with DDKS within ninety (90) calendar days from the date on which the service failure occurred.
- (c) A service failure will not be deemed to have occurred if, within ninety (90) calendar days after the Employer notifies DDKS, DDKS provides the Employer with:
 - (i) proof of timely transmittal or processing of material which the Employer claims to have constituted a service failure, and which the DDKS had undertaken to transmit or process within a given period; or
 - (ii) information showing that the claimed service failure resulted from circumstances described in Section 8.4, “Liabilities Not Assumed.”

8.3 Credits or refunds will be made only to the Employer. DDKS and Employer acknowledge that nothing in this Agreement contains any undertaking by DDKS for, or may be enforced by, any person other than the Employer.

8.4 Liabilities Not Assumed.

- (a) DDKS WILL NOT BE LIABLE, IN ANY EVENT, FOR ANY DAMAGES, WHETHER DIRECT, INCIDENTAL, SPECIAL OR CONSEQUENTIAL, RELATED TO ANY SERVICE FAILURE, INCLUDING, BUT NOT LIMITED TO, LOSS OF INCOME OR PROFITS, IN EXCESS OF THE APPLICABLE AMOUNTS SET FORTH IN SECTION 8.6, WHETHER OR NOT DDKS KNEW OR SHOULD HAVE KNOWN THAT SUCH DAMAGES MIGHT BE INCURRED. DDKS MAKES NO WARRANTIES, EXPRESS OR IMPLIED, OR REPRESENTATIONS OF ANY KIND NOT HEREIN EXPRESSLY STATED.
- (b) DDKS will not be liable for, nor shall any adjustment, refund, or credit of any kind be made as a result of any loss, damage, delay, or service failure except such as result from DDKS’ sole negligence, including without limitation any loss, damage, delay or service failure resulting from:
 - (i) acts or omissions of the Employer, including incorrect or incomplete information provided by the Employer to DDKS or the Employer’s failure to meet its obligations pursuant to a conversion or implementation of DDKS’ system;
 - (ii) national or local delays or disruption in transportation, delivery, telecommunications, or computer networks due to events beyond DDKS’ control (such as weather phenomena, labor disputes, or natural disasters); fire; acts of God; unavoidable casualties; acts of public authorities; and any other event beyond DDKS’ reasonable control;
 - (iii) acts or omissions of any person other than DDKS, including acts or omissions of Dentists and other individuals or entities providing services or information to DDKS.

8.5 If there is a conflict between the provisions of these Service Guarantees and the terms and conditions of any other written or oral statement issued by DDKS pertaining to service guarantees, the provisions of these Service Guarantees will control. DDKS reserves the right, by authorization of its President, to unilaterally, and from time to time in writing, prospectively modify, amend or supplement the provisions of

these Service Guarantees without notice, but no other agent or employee of DDKS is authorized to modify, amend, or supplement the provisions of these Service Guarantees.

8.6 Guarantees:

1. Claim Cost Containment

- (a) DDKS guarantees that, over the course of a Contract Year, each master plan design will realize a minimum five percent (5%) claims savings. This savings will result from the cost management features contained in DDKS' contracts with participating Dentists.
- (b) DDKS' performance under this first guarantee will be measured by data contained in a management report generated annually for the Employer by DDKS. If the report shows that DDKS did not achieve a reduction of at least five percent (5%), based on all of the Employer's claims experience for each master plan design over the course of the benefit calculation year, the Employer may request a refund or credit equal to the difference between five percent (5%) and the lesser amount actually saved.

2. Problem Solving

- (a) DDKS guarantees that Employer, Enrollees and Eligible Employees and/or their Dependents will be given accurate answers to questions directed to DDKS' service representatives and resolutions to related problems (or status updates if a problem cannot be immediately resolved) before the close of the business day immediately following the business day during which DDKS is informed of the question or related problem.
- (b) If DDKS fails to meet this service standard and such failure is reasonably documented by the Employer and submitted to DDKS in accordance with DDKS' standard Service Guarantee procedures, the Employer may request a credit or refund of fifty dollars (\$50) per service failure.

3. Claims Processing Turnaround Time

- (a) DDKS guarantees that, over the course of a Contract Year, ninety percent (90%) of all claims will be processed within fifteen (15) calendar days of receipt of a complete and accurate claim form, and the claims will be processed accurately.
- (b) DDKS' turnaround time performance will be measured by data contained in a management report generated annually for the Employer by DDKS. If the report shows that more than ten percent (10%) of the total of Employer's claims were not processed within fifteen (15) business days of DDKS' receipt of a complete and accurate claim form, the Employer may request a credit or refund of the administrative fee charged by DDKS for the last month of the Contract Year.

4. Smooth Conversion or Implementation

- (a) DDKS guarantees a smooth conversion (if Employer already offers dental insurance to Employees) or a smooth implementation (if Employer does not presently offer dental insurance to Employees) of the Plan.
- (b) DDKS and the Employer shall agree upon the criteria against which to measure DDKS' performance under this guarantee and will set forth such criteria in a conversion checklist containing, among other things, services required from DDKS, deliveries required from the Employer, submittal deadlines for both DDKS and Employer, and the time period within smooth conversion or implementation will be completed.
- (c) If the checklist is adhered to by the Employer and a smooth conversion or implementation is not achieved within the time period agreed upon, then the Employer may request a credit or refund of the administrative fee charged by DDKS for the second month of the Policy Year.

5. Balance Billing

- (a) DDKS guarantees that its participating Kansas Dentists will not bill Enrollees for any portion of the balance remaining above the Maximum Plan Allowable on any claim for Covered Services after payments by DDKS (and by Enrollee, if any payment is required under this Agreement) has been made.
- (b) If balance billing by a participating Kansas Dentist occurs, and such balance billing is acceptably documented by the Employer and submitted to DDKS in accordance with DDKS' standard Service Guarantee procedures, the Employer may request a credit or refund equal to fifty dollars (\$50) per documented occurrence.
- (c) By way of example, this Agreement provides that Enrollees are responsible for payment of a variety costs resulting from general limitations and exclusions of benefits; limitations and exclusions of benefits based on professional review of services; co-insurance and Deductibles, and eligibility denials.

SIGNATURE PAGE

In witness whereof, the parties have caused this Agreement to be signed by their authorized representatives.

EMPLOYER
NAME DERBY USD 260

By: Don Adkisson
(Authorized Signature)

By: Don Adkisson
(Authorized Printed Name)

Director of Finance
(Title)

Date: 5-20-2011

DELTA DENTAL OF KANSAS, INC.

By: Linda L Brantner
(Authorized Signature)

President and CEO
(Title)

Date: April 14, 2011

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APPENDIX C HEALTH FLEXIBLE SPENDING ACCOUNT

This Appendix C contains the terms and conditions specific to the USD 260 – Derby Public Schools Health Flexible Spending Account, benefit that may be elected under Section 4.01 of the Plan. Under this benefit, a Participant may be reimbursed, on a pre-tax basis, for Qualified Medical Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix C, the terms and conditions of the Plan are incorporated into and made applicable to the Health FSA.

ARTICLE C-I PARTICIPATION IN THE HEALTH FLEXIBLE SPENDING ACCOUNT

Section C1.01 Eligibility / Plan Entry Dates. The eligibility conditions and plan entry dates are the same as those for the Plan.

Section C1.02 Election to Participate. To become a Participant in this Health FSA, an Eligible Employee must make an election under the Plan to participate in this Health FSA. Such an election must be made pursuant to the terms and provisions of the Plan.

- (a) *Special Rule for Carryover Amounts.* If a Participant does not elect to participate in the Health FSA for the Plan Year, but the Participant has a Carryover Amount (defined below) from a prior Plan Year, the Participant will be automatically re-enrolled in this Health FSA with an election of zero dollars. The sole purpose of the election of zero dollars is to allow the Participant the opportunity to spend the Carryover Amount. This special rule for Carryover Amounts shall apply unless an affirmative forfeiture has been made by the Participant as set forth in subparagraph (b) below.
- (b) *Affirmative Forfeiture of Carryover Amount.* A Participant may affirmatively and voluntarily forfeit his/her Carryover Amount if he/she does not want to be automatically re-enrolled with a zero dollar election, as set forth in subparagraph (a) above. Such affirmative and voluntary forfeiture must be made on a form prescribed by either the Plan Administrator or Claims Administrator.
- (c) *Special Rule if Enrolled in the High Deductible Health Plan Option.* In the event a Participant with a Carryover Amount from a prior Plan Year enrolls in a high deductible health plan sponsored or maintained by the Employer, and the Participant is eligible to enroll in a Limited-Scope Health FSA that is sponsored or maintained by the employer, the Plan Administrator, may establish a procedure whereby, in the absence of an affirmative election by the Participant to the contrary, any Carryover Amount is automatically carried forward from the Employer's General-Purpose Health FSA to the Employer's Limited-Scope Health FSA.

Section C1.03 Effective Date of Election. An election to participate in this Health FSA shall take effect as follows:

- (a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year;
- (b) If the Eligible Employee's election was made (and the completed election form was received by the Plan Administrator) before the date the Eligible Employee becomes a Participant in the Plan, the election shall take effect as of the date the Eligible Employee becomes a Participant; or
- (c) If the Eligible Employee's election was made within thirty (30) days after an event that would allow an election change to be made under the terms of the Plan, the election shall take effect as of the first day of the month on or after the date that the completed election form is received by the Plan Administrator; provided, however, that this Section C1.03(c) shall apply if and only if the Eligible Employee had not previously been a Participant in this Health FSA at any time during the Plan Year.

Section C1.04 Election Changes. Once an Eligible Employee has become a Participant in this Health FSA, he/she may make an election change after the beginning of a Plan Year in accordance with, and as permitted by, Article V.

Section C1.05 FMLA Leave. A Participant who is taking or returning from FMLA leave shall have the following options with respect to his/her participation in this Health FSA:

- (a) *Taking FMLA Leave.* Upon commencement of FMLA leave, a Participant may continue his/her coverage under this Health FSA by continuing to pay the applicable premium during the period of the FMLA leave or by making such other arrangements as may be permitted under the provisions of the Plan. Alternatively, upon commencement of FMLA leave, a Participant may revoke his/her participation in this Health FSA, in which event the Participant will no longer be covered under this Health FSA as of the date that his/her FMLA leave commenced.
- (b) *Returning from FMLA Leave.* If a Participant's participation in this Health FSA was terminated when the Participant began his/her FMLA leave, the former Participant may, upon returning to work from an FMLA leave, elect to resume his/her participation in this Health FSA as of the date that he/she returns to work.
 - (i) Such a Participant may elect to resume coverage at the prior coverage level, in which event the Participant will be required to make up the premiums that would have been due during the period the Participant was on FMLA leave.

- (ii) In lieu of making up the missed premiums, such a Participant may instead choose to resume coverage at a reduced level. In such an event, the Participant's coverage for the Plan Year shall be reduced on a pro rata basis by the portion of the Plan Year that the Participant was absent from work due to his/her FMLA leave.

ARTICLE C-II MEDICAL REIMBURSEMENT

Section C2.01 Definition of a Dependent. The term "Dependent," for purposes of participation in this Health FSA, means the following:

- (a) *Children Through Age 26.* The Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, until such child attains age 26 (or until such child attains age 18 in the case of a legal guardianship). Children placed with a Participant for adoption and Children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.
- (b) *Disabled Children Above Age 26.* The Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical disability and for whom the Participant is the major source of financial support, from the end of the calendar month in which the Child attains age 26.
- (c) *Non-Children Dependents.* Any relatives of the Participant who reside in the Participant's home, are claimed by the Participant as a tax dependent, and meet the definition of a tax dependent under Code § 152. This includes "any qualifying relative within the meaning of Code § 152(a)(2), without regard to subsections (b)(1), (b)(2) or (d)(1)(B)."

Section C2.02 Qualified Medical Expense. The term "Qualified Medical Expense" means an expense incurred by the Participant, or by the Spouse or Dependent (as defined in Section C2.01 above) of a Participant, for medical care as defined in Code § 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. The term includes reimbursable Qualified Medical Expenses described under Section C2.06. It does not include premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer).

Section C2.03 Carryover Amount. For purposes of reimbursements under this Health FSA, the Carryover Amount, if such amount remains in the Participant's account from the immediately preceding Plan Year, is equal to *the lesser of* the dollar limit set by the Employer *or* the dollar limit for carryovers set forth in IRS Notice 2013-71, as amended by IRS Notice 2020-33, and as adjusted annually by the IRS to reflect changes in the cost of living. The Carryover

Amount is determined on the last day of the Run-Out Period for that Plan Year. Any amount remaining in excess of the Carryover Amount shall be forfeited.

Section C2.04 Run-Out Period. The Run-Out Period means the period following the end of the Plan Year during which the prior Plan Year Claims may be submitted to the Employer for reimbursement. The Run-Out Period under this Health FSA ends on March 31st.

Section C2.05 Reimbursement.

- (a) *General Rule.* The Employer will reimburse the Participant in the Plan Year for Qualified Medical Expenses incurred by the Participant during the Plan Year subject to the other limitations of this Health FSA.
- (b) *Special Carryover Rule.* A Participant may also be reimbursed for Qualified Medical Expenses in a subsequent Plan Year from his/her Carryover Amount.

Unless specifically requested otherwise by a Participant, reimbursements during the Run-Out Period for current-year claims will be made from current-year amounts in order to maximize the potential Carryover Amount.

- (c) *Electronic Payments.* If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Medical Expenses at merchants and service providers which are authorized by the Employer.

The Employer will not make any reimbursement to a Participant if the Participant receives reimbursement for the expense through insurance or under any other means. The Employer will only reimburse for Qualified Medical Expenses incurred while the employee participates in the Health FSA. An expense is incurred when the Participant is provided with the medical care that gives rise to the Qualified Medical Expenses, and not when the Participant is formally billed or charged for, or pays for the medical care.

Section C2.06 Reimbursable Qualified Medical Expenses. The following expenses constitute Qualified Medical Expenses, as defined in C2.01, that may be reimbursed under this Health FSA:

- (a) Deductibles and copayment amounts the Participant pays under his or her medical and/or dental and/or vision care coverage, which includes amounts paid for hospital bills, and doctor and dental bills;
- (b) Medical and/or dental and/or vision care expenses in excess of usual, reasonable and customary rates; and
- (c) Any Code § 213(d) medical, dental, or vision care expenses not reimbursed by insurance or otherwise, including medicine and drugs (whether purchased over-the-counter or with a prescription), and certain menstrual products (as defined in Code § 223(d)(2)(D)).

The Plan Administrator has discretion to construe and apply what may be reimbursable under this Plan in accordance with such final or informal guidance as the IRS might provide.

Section C2.07 Maximum Amount of Reimbursement. The maximum amount of reimbursement for any Plan Year is the dollar amount that the Participant elected to contribute to his/her Health FSA for that Plan Year, plus the amount, if any, of the contributions made by the Employer to the Participant's Health FSA for that Plan Year. In addition, the maximum amount of reimbursement for any Plan Year will include the amount, if any, of the Carryover Amount from the previous Plan Year. The Employer will reimburse the Participant throughout the coverage period for Qualified Medical Expenses up to the maximum amount of reimbursement, as set forth in this Section, without regard to the actual amount that the Participant has contributed to his/her Health FSA as of the date a claim for reimbursement was submitted.

- (a) *Limit on Amounts Elected by the Participant*. The dollar amount elected by the Participant may not exceed the dollar limit established by the Employer for that Plan Year.
- (b) *Dollar Limit Established by the Employer*. The dollar limit established by the Employer for a Plan Year will be equal to the dollar limit set forth in the Code (as indexed annually for cost-of-living adjustments by the IRS); provided, however, that the Employer may elect to establish a lower dollar limit for a Plan Year.
- (c) *Communication to Eligible Employees*. The dollar limit established by the Employer for a Plan Year must be communicated by the Plan Administrator to Eligible Employees in the enrollment materials for the Health FSA.
- (d) *Special Carryover Rule*. The maximum reimbursement amount as set forth in this Section may be increased by any Carryover Amount, as defined in Section C2.03 above.

Section C2.08 Withholding - Accounting. The Employer will establish and maintain a Health FSA for each Participant who has elected to receive the Health FSA benefit under this Health FSA. The Employer will credit to the Participant's Health FSA an amount of the Participant's Compensation which he or she elects to reduce. The amounts credited to the Participant's Health FSA are the property of the Employer until the Employer actually makes reimbursement to the Participant. The Employer will debit a Participant's Health FSA for the amount of the reimbursement made for the Participant. A Participant's Health FSA will never exceed the dollar amount specified in Section C2.07 above of this Health FSA.

Section C2.09 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's Health FSA for any Plan Year to reimburse the Participant for Qualified Medical Expenses or to make a "qualified reservist distribution" in accordance with Article C-IV, Sections C4.01 through C4.06 of this Appendix C. If any balance, other than any portion of the balance that qualifies as a Carryover Amount, remains in the Participant's Health FSA for any Plan Year after the Employer has made the reimbursements and/or "qualified

reservist distribution" for the Plan Year, the Participant will forfeit the unused amount. Within a given Plan Year, if the total forfeitures from all Participants exceed the total reimbursement amount, then the Health FSA will have a surplus. The amount of the surplus, if any, will be determined after *the later of* the end of the Claims Run-Out Period, defined in C2.04, and after all pending claims have been processed. Any surplus will be used to offset reasonable administrative costs. Any excess still remaining after such costs are paid will be used to reduce the required premiums under the Health FSA for all Employees participating in the Health FSA in the Plan Year following the Year in which the surplus was created. Participants for this purpose will be determined on the date of the first payroll following the date on which the amount of surplus has been determined.

Section C2.10 Termination of Health FSA by the Employer - Forfeitures. If the Health FSA is terminated by the Employer either before or at the end of the Plan Year and the total contributions from all Participants exceed the total Health FSA reimbursements then the Employer will use the surplus to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed *per capita* to all Participants who participated in the Health FSA in the year in which the surplus was gained. In no case will the surplus be allocated to a Participant based directly or indirectly on his or her Claims experience. The administrative costs will not be offset and the surplus, if any, will not be distributed until the Claims Run-Out period has expired and all pending claims have been processed.

Section C2.11 Recoupment of Underwithheld Amounts. In the event that the amount withheld from a Participant's salary for his/her Health FSA contribution is less than the amount that should have been withheld pursuant to the Participant's election, whether by fault of the Participant or the Employer, the Employer shall seek recoupment of the amount of the insufficient withholding.

Section C2.12 Minimum Election Amount. The dollar amount elected by the Participant may not be less than the dollar amount established by the Employer for that Plan Year.

Section C2.13 Minimum Reimbursement. No reimbursement under this Health FSA shall be made if the Participant's Claim is for an amount less than \$25 or such lesser minimum reimbursable amount as may be established by the Plan Administrator. The amount of any Qualified Medical Expense not reimbursed as a result of the minimum reimbursable amount shall be carried over and reimbursed only if and when the Participant's unreimbursed Claims equal or exceed such minimum. Notwithstanding the preceding sentence, Claims for expenses incurred during a Plan Year that are submitted for reimbursement in or carried over to the last month of the Plan Year or pursuant to the termination of participation in this Health FSA, shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided they do not exceed the remaining balance in the Participant's health flexible spending account.

ARTICLE C-III CLAIMS PROCEDURE

Section C3.01 Submission of Claims. A Participant desiring to be reimbursed for medical expenses must apply for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his or her Health FSA through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section C3.03. Subject to Section C4.01 of this Plan, a Participant must submit the application for reimbursement for expenses incurred during a Plan Year before the end of the Run-Out Period, defined in Section C2.04. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

- (a) The amount, date incurred, and nature of each expense;
- (b) The name of the person, organization, or entity with whom the expense was incurred;
- (c) The name of the person for whom the expense was incurred;
- (d) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and
- (e) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other statements or documents that the Claims Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Section C3.02 Claims Administration. Surency Life & Health will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Surency Life & Health is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

Section C3.03 Electronic Payment Card Reimbursements. If the funds in a Health FSA are accessible by electronic debit card a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. A debit card that is presented as payment for a medical expense and denied at the point-of-sale (i.e., when the service or item is provided) does not constitute an initial claim denial under these procedures.

Section C3.04 Limitation on Reimbursements With Respect to Certain Participants. Notwithstanding any other provision of this Health FSA, the Plan Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated individual (within the meaning of Code §105(h)(5) or §125(e)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section C2.09 of this Health FSA.

Section C3.05 Time Frame for Deciding Claims. If any Claim for benefits under this Health FSA is denied, in whole or in part, then the Claim Administrator shall promptly furnish to the Claimant, within thirty (30) days of receipt of the Claim, written notice:

- (a) Setting forth the reason for the denial;
- (b) Making reference to pertinent Health FSA provisions upon which the denial is based;
- (c) Describing any additional material or information from the Claimant which is necessary and why; and
- (d) Referencing any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination (if applicable).

Section C3.06 Extension of Time Frame for Deciding Claims. The Claim Administrator may seek one extension of up to fifteen (15) days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan and the Claimant must be notified of the extension prior to the expiration of the initial thirty (30) day period. If the extension is due to the failure of the Claimant to submit information necessary to decide the Claim, the notice of extension shall specifically describe the required information and the Claimant shall have at least forty-five (45) days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which the Claimant responds to the request for information.

Section C3.07 Appealing a Claim Denial. Any Claimant seeking review hereunder has one hundred eighty (180) days to submit the Appeal. The Claimant may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

Section C3.08 Time Frame for Deciding Appeal. The Plan Administrator shall render a decision on review no later than sixty (60) days after receipt of the request for review hereunder unless special circumstances require an extension of time (not to exceed 60 days from the date of the initial 60-day period). The Participant shall be furnished with written notice of any such extension.

Section C3.09 Decision on Appeal. In conducting the review, no deference shall be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the Claim (or the person's subordinate), shall make the determination upon Appeal. The decision on review shall be in writing. If the Claim is once again denied, in whole

or in part, then the notification shall (a) state the reason for the decision, (b) refer to the Health FSA provisions upon which it is based, (c) state that the Claimant is entitled to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, and (d) describe any voluntary Appeals procedures.

ARTICLE C-IV QUALIFIED RESERVIST DISTRIBUTIONS

Section C4.01 Qualified Reservist Distributions ("QRD"). A "qualified reservist distribution" is a distribution of all or a portion of the account balance of a Participant who is called to active military service, provided the call to active military service is for a period of one hundred eighty 180 or more days or for an indefinite period of time.

Section C4.02 Amount of the QRD. Unless a lesser amount is specifically requested, the QRD will be the total of the Participant's contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

Section C4.03 Time Frame for Requesting a QRD. A Participant must request a QRD on or after the date the Participant is called to active military service and prior to the end of the Run-Out Period immediately following the Plan Year in which the Participant is called to such service.

Section C4.04 Time Frame for Plan Administrator to Respond to a Request for a QRD. The Claims Administrator shall respond to any timely request for a QRD within sixty (60) days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth in Article C-III of this Appendix C, except that the time frame set forth in Section C3.05 shall be sixty (60) days instead of thirty (30) days.

Section C4.05 Eligible Claims. A Participant who requests a QRD forfeits the right to receive reimbursements for Qualified Medical Expenses incurred after the date of his/her last day of active employment. Such Participant shall be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment, provided that the total dollar amount of such claims does not exceed the amount of the Participant's election minus the sum of his/her QRD and prior reimbursements received for the Plan Year.

Section C4.06 No Penalty on QRD. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in the Participant's gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

ARTICLE C-V
TERMINATION OF PARTICIPATION IN THE
HEALTH FLEXIBLE SPENDING ACCOUNT AND
CONTINUATION OF COVERAGE

Section C5.01 Termination of Participation.

- (a) *General Rule.* A Participant will cease participation in this Health FSA on the earlier of the following dates:
 - (i) The date on which this Health FSA terminates; or
 - (ii) The date on which the Participant ceases to be an Eligible Employee.
- (b) *Effect of Ceasing to be a Participant.* If a Participant ceases to be a Participant in this Health FSA for any reason, the Participant's election to receive reimbursements for Qualified Medical Expenses terminates on that date. The Participant may only receive reimbursement for Qualified Medical Expenses incurred within the same Plan Year and prior to the first day after the day the Participant terminates participation in this Health FSA.
- (c) *Continuation Coverage.* Notwithstanding anything in this section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Health FSA if and to the extent such an individual elects continuation of benefits under the rules in Section C5.02 below.
- (d) *Reimbursement.* If a Participant ceases participation under this Health FSA, the Participant must apply for reimbursement in accordance with Article C-III within the 30-day period following the date the Participant ceases to be a Participant.
- (e) *Electronic Payment Card.* A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his or her Health FSA, effective the date of his/her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

Section C5.02 Continuation of Coverage. A Participant who will lose coverage under this Health FSA may have the right to continue coverage under this Health FSA if permitted under the terms and conditions of Article VIII except that (a) COBRA continuation coverage will not be offered if the Participant has overspent his/her account and (b) the maximum period of COBRA coverage described in Section 8.01(e) is limited to the remainder of the Plan Year.

Section C5.03 Limits on Continuation Coverage. Reimbursements under Section C5.02 above shall be made for expenses incurred in any Plan Year only if the Participant applies for such reimbursement in accordance with Article C-III within the Run-Out Period following the close of the Plan Year. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements pursuant to Article C-III above. No reimbursement shall exceed the remaining balance, if any, in the Participant's health flexible spending account for the Plan Year in which the expenses were incurred.

APPENDIX D DEPENDENT CARE ASSISTANCE PLAN

This Appendix D contains the terms and conditions specific to the USD 260 – Derby Public Schools Dependent Care Assistance Plan, that may be elected under Section 4.01 of the Plan. Under this DCAP, a Participant may be reimbursed, on a pre-tax basis, for Qualified Dependent Care Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix D, the terms and conditions of the Plan are incorporated into and made applicable to this DCAP.

ARTICLE D-I PARTICIPATION IN THE DEPENDENT CARE PLAN

Section D1.01 Eligibility / Plan Entry Dates. The eligibility conditions and plan entry dates are the same as those for the Plan.

Section D1.02 Election to Participate. To become a Participant in this DCAP, an Eligible Employee must make an election under the Plan to participate in this DCAP. Such an election must be made pursuant to the terms and provisions of the Plan.

Section D1.03 Effective Date of Election. An election to participate in this DCAP shall take effect as follows:

- (a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year;
- (b) If the Eligible Employee's election was made (and the completed election form was received by the Plan Administrator) before the date the Eligible Employee becomes a Participant in the Plan, the election shall take effect as of the date the Eligible Employee becomes a Participant; or
- (c) If the Eligible Employee's election was made within thirty (30) days after an event that would allow an election change to be made under the terms of the Plan, the election shall take effect as of the first day of the month on or coincident with the date that the completed election form is received by the Plan Administrator.

Section D1.04 Election Changes. A Participant in this DCAP may change his/her election during the middle of a Plan Year, either as to participation in this DCAP or as to the dollar amount of the benefit elected, if and only if such an election change is permitted under the terms of the Plan.

ARTICLE D-II DEPENDENT CARE REIMBURSEMENT

Section D2.01 Qualified Dependent Care Expense. The term “Qualified Dependent Care Expense” means an amount paid by the Participant for care of a Dependent, including related household services, which enables the Participant to be gainfully employed.

- (a) *Dependent Care Expenses That Are Not “Qualified.”* Qualified Dependent Care Expenses do not include the following:
 - (i) Amounts paid to a child of the Participant who is under age 19;
 - (ii) Amounts paid to an individual for whom the Participant or the Participant’s Spouse is entitled to an exemption under Code § 151(c); and
 - (iii) Amounts paid to a dependent care center that is not a Dependent Care Center as defined in Section (d) below.
- (b) *Special Rule for Services Performed Outside the Home.* Amounts paid for services performed outside the Participant’s household are not Qualified Dependent Care Expenses unless the expenses are for a Dependent as defined in Section (c)(i) below or a Dependent as defined in Section (c)(ii) below who spends at least eight (8) hours each day in the Participant’s home.
- (c) *Dependent.* For purposes of this DCAP benefit, the term “Dependent” means an individual meeting the conditions under subparagraphs (i), (ii), or (iii) below as follows:
 - (i) A tax dependent of the Participant as defined in Code § 152 who is:
 - (A) under the age of 13; and
 - (B) the Participant’s qualifying child as defined in Code § 152(a)(1).

or
 - (ii) A tax dependent of the Participant as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2) and (d)(1)(B), who:
 - (A) is physically or mentally incapable of caring for himself/herself; and
 - (B) has the same principal place of abode of the Participant for more than one-half of the calendar year;

or
 - (iii) A Participant’s Spouse who:
 - (A) Is physically or mentally incapable of caring for himself/herself; and

- (B) Has the same principal place of abode of the Participant for more than one-half of the calendar year.

Notwithstanding the foregoing, and in accordance with Code § 21(e)(5), in the case of divorced or legally separated parents, a Dependent who is a child shall be treated as a Dependent of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Dependent of the non-custodial parent.

- (d) *Dependent Care Center.* The term “Dependent Care Center” means a facility, organized and operated in compliance with all applicable laws and regulations, for care of more than six (6) persons, including one (1) or more dependents of the Participant, other than persons who reside there and which facility receives a fee, payment or grant for providing services for any of the six (6) individuals regardless of whether the facility operates at a profit.

Section D2.02 Grace Period. For purposes of reimbursements under this DCAP, Grace Period means the period that begins immediately following the close of a Plan Year and ends on the March 15th immediately following the close of the Plan Year.

Section D2.03 Run-Out Period. The Run-Out Period means the period following the end of the Grace Period during which the prior Plan Year Claims may be submitted to the Employer for reimbursement. The Run-Out Period under this DCAP ends on March 31st.

Section D2.04 Reimbursement. The Employer will reimburse a Participant for his/her Qualified Dependent Care Expenses incurred by the Participant during the Plan Year subject to the other limitations of this DCAP. The Employer will only reimburse for Qualified Dependent Care Expenses incurred while the Employee participated in the DCAP benefit under the Plan. An expense is incurred when the Participant is provided with the care that gives rise to the Qualified Dependent Care Expense, and not when the Participant is formally billed or charged for, or pays for the care.

- (a) *Special Grace Period Rule.* A Participant may also be reimbursed for Qualified Medical Expenses incurred during the Grace Period from amounts remaining in his or her account at the end of the Plan Year to which that Grace Period relates if he or she is a Participant with DCAP coverage that is in effect on the last day of that Plan Year.

Unless specifically request otherwise, reimbursements during the Grace Period will be made according to the order in which the request for reimbursement is received. Reimbursements will be made from the immediately preceding Plan Year’s account until there is no amount remaining in such account and then from the current Plan Year’s account.

- (b) *Electronic Payments.* If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Dependent Care Expenses at merchants and service providers which are authorized by the Employer.

Section D2.05 Reimbursable Qualified Dependent Care Expenses. Reimbursable Qualified Dependent Care Expenses do not include:

- (a) Education expenses for a child in kindergarten or any higher grade;
- (b) Overnight care at a convalescent nursing home for a Dependent;
- (c) Overnight camp;
- (d) Expenses for lessons, tutoring, or certain types of transportation expenses;
- (e) Expenses paid through another policy or DCAP of the Participant or the Participant's Spouse;
- (f) Forfeited deposits, but may include application fees, agency fees, and deposits if the Participant is required to pay the expenses to obtain dependent care; or
- (g) Expenses incurred before the Participant elected to participate in the DCAP benefit.

Section D2.06 Maximum Amount of Reimbursement. The maximum amount of reimbursement during a Plan Year may not exceed the lesser of the exclusion amount or the earned income limitation. A Participant may not carry over an unused amount to a succeeding year. The exclusion amount for any Plan Year is \$5,000 (\$2,500 if a married person filing a separate return). The same maximum amount of reimbursement applies per calendar year as specified by the Code. The earned income limitation is the earned income of an unmarried Participant or, for a married Participant, the lesser of the earned income of the Participant or the Participant's Spouse. The Claims Administrator will determine earned income pursuant to Code § 32(c)(2). In no event will the Employer reimburse more than the dollar amount elected by the Participant. Additionally, in no event will the Employer reimburse more than the dollar amount actually credited to the Participant's DCAP for the year minus amounts previously reimbursed for the year.

- (a) *Special Grace Period Rule.* A Qualified Dependent Care Expense incurred during the Grace Period may be reimbursed from money remaining in a Participant's account for the related Plan Year provided that the Claim is submitted within the Run-Out Period. All Qualified Dependent Care Expenses incurred during the Grace Period must be submitted in paper form and not through the use of an electronic payment card, such as a debit card.

Section D2.07 Withholding - Accounting. The Employer will establish and maintain a DCAP for each Participant who has elected to receive the DCAP benefit under the Plan. The Employer will credit to the Participant's DCAP an amount of the Participant's Compensation which he or she elects to reduce. The amounts credited to the Participant's DCAP are the property of the Employer until the Employer actually makes reimbursement. The Employer will debit a Participant's DCAP for the amount of the reimbursement made to the Participant. A Participant's DCAP will never exceed the maximum amount specified in Section D2.04 above.

Section D2.08 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's DCAP for any Plan Year to reimburse the Participant for Qualified Dependent Care Expenses. If any balance remains in the Participant's DCAP for any Plan Year after the Employer has made all reimbursements for the Plan Year and the immediately following Grace Period, the Participant will forfeit the unused amount. Within a given Plan Year, if the total forfeitures from all Participants exceed the total reimbursement amount, then the DCAP will have a surplus. The amount of the surplus, if any, will be determined after the later of the end of the Grace Period defined in D2.02 or the end of the Claims Run-Out Period, defined in D2.03, and after all pending Claims have been processed. Any surplus will be used to offset reasonable administrative costs. Any excess still remaining after such costs are paid will be used to reduce the required premiums under the DCAP for all Employees participating in the DCAP in the Plan Year following the Year in which the surplus was created. Participants for this purpose will be determined on the date of the first payroll following the date on which the amount of surplus has been determined.

Section D2.09 Minimum Election Amount. The dollar amount elected by the Participant may not be less than the dollar amount established by the Employer for that Plan Year.

Section D2.10 Minimum Reimbursement. No reimbursement under this DCAP shall be made if the Participant's Claim is for an amount less than \$25 or such lesser minimum reimbursable amount as may be established by the Claims Administrator. The amount of any dependent care expense not reimbursed as a result of the minimum reimbursable amount shall be carried over and reimbursed only if and when the Participant's unreimbursed Claims equal or exceed such minimum. Notwithstanding the preceding sentence, Claims for expenses incurred during a Plan Year or the immediately following Grace Period that are submitted for reimbursement in or carried over to the last month of the Grace Period or pursuant to the termination of participation in this DCAP, shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided they do not exceed the remaining balance in the Participant's dependent care spending account.

ARTICLE D-III CLAIMS PROCEDURES

Section D3.01 When to File a Claim. Subject to Section D 4.01 of this Appendix D, the Participant must submit the application for reimbursement for expenses for a Plan Year no later than the end of the Run-Out Period.

Section D3.02 How to Submit Claims. A Participant desiring to be reimbursed for Qualified Dependent Care Expenses must make a Claim for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his or her DCAP through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section D3.03. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

- (a) The amount and date of services rendered and the nature of each expense with respect to which a benefit is requested;

- (b) The name of the person, organization, or entity to which the expense was or is to be paid;
- (c) The signature of the daycare provider; and
- (d) Such other information as the Claims Administrator may from time to time require.

Such application shall be accompanied by bills, invoices, receipts, or other statements or certifications showing the amounts of such expenses, together with any additional documentation which the Employer may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Claims may be filed by the Participant or by the Participant's duly authorized representative. Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

Section D3.03 Claims Decisions. Surency Life & Health will act as Claims Administrator with respect to any Claims for benefits under this DCAP. Surency Life & Health has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section D3.04 Electronic Payment Card Reimbursements. If the funds in a DCAP are accessible by electronic debit card a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance.

Section D3.05 Limitation on Reimbursements with Respect to Certain Participants. No more than twenty five percent (25%) of the total amounts reimbursed from all dependent care assistance accounts maintained by all Participants under this DCAP during any Plan Year may be reimbursed with respect to the class of individuals who own more than five percent (5%) of the stock of the Employer (or their Spouses or dependents). Notwithstanding any other provision of this DCAP, the Claims Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated employee (within the meaning of Code § 414(g)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with the restriction described in the preceding sentence or with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section D2.08 above.

Section D3.06 Time Frame for Deciding Claims. The Claim for reimbursement shall be approved or denied within a reasonable period (but no later than 90 days) after receipt of the Claim by the Claims Administrator. The initial 90-day period begins at the time the Claim is filed whether or not all the necessary information for determining the Claim is provided at that time.

Section D3.07 Extension of Time Frame for Deciding Claims. Notwithstanding Section D3.06 above, if the Claims Administrator determines that special circumstances require an extension of time (up to 90 days from the end of the initial 90-day period) for processing the Claim for reimbursement, written notice of the extension shall be furnished to the Participant before the end of the initial 90-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Section D3.08 Notification Regarding the Claim Decision. If any Claim for reimbursement of expenses under this DCAP is denied, in whole or in part, then the Claims Administrator shall furnish the Participant written notice within the applicable time periods described in D3.06 or D3.07 above:

- (a) Setting forth the reason for the denial;
- (b) Making reference to pertinent DCAP provisions upon which the denial is based;
- (c) Describing any additional material or information from the Participant which is necessary and why; and
- (d) Explaining the Claim review procedure and the applicable time frames set forth herein.

Section D3.09 Right to Appeal the Decision. Within sixty (60) days after receipt of the notification of the denial to reimburse an expense, the Participant may request in writing a review of the denial by the Claims Administrator.

Section D3.10 Time Frame for Deciding Appeal. Subject to D3.11 below, the Claims Administrator shall render a decision on review of a denied Claim within a reasonable period of time, but no later than sixty (60) days after receipt of the request for review hereunder unless special circumstances require an extension of time.

This 60-day period begins at the time an Appeal is filed without regard to whether all the information necessary to determine on review whether an expense is reimbursable accompanies the filing. However, if an extension is required, as described below, due to the Participant's failure to submit necessary information, the period of time for making the determination shall be tolled from the date on which the notification of extension is sent to the Participant until the date on which the Participant responds to the request.

Section D3.11 Sixty (60) Day Extension of Time. If the Claims Administrator determines that special circumstances require an extension of time (up to 60 days from the end of the initial 60-day period) for processing the Claim, written notice shall be furnished to the Participant before the end of the initial 60-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on Appeal.

Section D3.12 Decision on Appeal. In the case of an adverse decision on Appeal, the Claims Administrator shall send the Participant a notification:

- (a) Setting forth the reason for the denial;
- (b) Making reference to pertinent DCAP provisions upon which the denial is based;
- (c) Stating the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
- (d) Explaining any voluntary Appeals procedures and the Participant's right to information regarding these procedures, if any.

ARTICLE D-IV TERMINATION OF DEPENDENT CARE ASSISTANCE PLAN

Section D4.01 Termination of Participation.

- (a) *General Rule.* A Participant will cease participation in this DCAP on the earlier of the following dates:
 - (i) The date on which this DCAP terminates; or
 - (ii) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this DCAP terminates on the above date, coverage or benefits under the Pre-Tax Benefits may continue if and to the extent provided by such Pre-Tax Benefits.

- (b) *Effect of Ceasing Participation.* If a Participant ceases to participate in this DCAP for any reason, the Participant's election to receive reimbursements for Qualified Dependent Care Expenses terminates on that date. A Participant may receive reimbursement only for Qualified Dependent Care Expenses incurred within the same DCAP Year and only during the period that the Participant was a Participant in this DCAP. If a Participant ceases participation under this DCAP, the Participant must apply for reimbursement in accordance with Article D-III within the 30-day period following the date the Participant ceases to be a Participant.
- (c) *Electronic Payment Card.* A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his/her DCAP, effective the date of his or her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

APPENDIX E VISION PLAN

This Appendix E contains the terms and conditions specific to the USD 260 - Derby Public Schools Vision Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix E, the terms and conditions of the Plan are incorporated into and made applicable to this Vision Plan.

Section E1.01 Eligibility / Plan Entry Dates. The eligibility conditions and the Vision Plan entry dates are the same as those for the Plan.

Section E1.02 Vision Benefits. Benefits under this Vision Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("Surency Life & Health Group Contract") between Surency Life & Health ("Surency") and the Employer. The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Surency. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Vision Plan shall be determined from the Surency Group Contract. The Participant shall bear fully any and all risk of Surency's insolvency.

Section E1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Surency Group Contract. Under the terms of the Group Contract, Surency may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section E1.04 Election to Participate. A Participant who desires to receive vision insurance coverage under this Vision Plan must elect to participate in this Vision Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive vision coverage under this Vision Plan, the Employer will not provide him/ her with any vision insurance coverage.

Section E1.05 Payment of Premium. A Participant who has elected to participate in this Vision Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section E1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) ineligible employees as defined in Section 2.12(b) of the Plan, all premiums must be paid through pre-tax salary reductions.

Section E1.06 Continuation of Coverage. An individual who will lose coverage under this Vision Plan may have the right to continue coverage under this Vision Plan as described in Article VIII.

Section E1.07 Children Subject to a QMCSO. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Vision Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such NMSN.

Section E1.08 Claims Administration. Surency will act as Claims Administrator with respect to any claim for benefits under this Vision Plan. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section E1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Vision Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Vision Plan if and to the extent such individual elects continuation of benefits under the rules in Section E1.06.

Section E1.10 Character of Benefits Provided. This Vision Plan does not provide vision treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular vision service may not be eligible for reimbursement under this Vision Plan does not mean that a Participant or other person who is covered under this Vision Plan should not receive that service.



OPTION #1

Summary of Proposed Vision Plan Benefits
U S D #260 - DERBY
Effective for February 1, 2014

SERVICES	IN NETWORK MEMBER COST	OUT OF NETWORK ALLOWANCES	FREQUENCY
Vision Examination with Dilation as Necessary	\$10	\$35	Once every 12 months
Contact Lens Fit and Follow-Up: (Contact lens fit and two (2) follow-up visits are available once a comprehensive eye exam has been completed.) Standard -spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.) Premium -all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	\$0 10% off Retail, then apply \$55 Allowance	\$40 \$40	Once every 12 months Once every 12 months
Frames: Any available frame at provider location.	\$130 Allowance	\$65	Once every 12 months
Standard Plastic Lenses: Single Vision Bifocal Trifocal	\$25 Copay \$25 Copay \$25 Copay	\$25 \$40 \$55	Once every 12 months
Lens Options: Standard Polycarbonate UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Premium Progressive Other Add-Ons and Services	Adults: \$40. Dependents: under 19 \$0 \$15 \$15 \$15 \$45 \$65 \$65+ 80% of Retail, less \$120 20% off Retail Price	\$25 Not Covered	Once every 12 months Once every 12 months
Contact Lenses: (Contact lens allowance includes materials only) (Allowance not available if eyeglass lenses are elected) Conventional Disposable Medically Necessary	\$130 allowance, 15% off balance over \$130 \$130 allowance \$0	\$100 \$100 \$200	Once every 12 months

Service frequencies are computed by date of service, not calendar year.

A child is eligible for coverage under the Plan if the child is under the age of twenty-six (26).

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

This is a Summary of benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.

Additional Value Added Savings:

- Members will receive a 20% discount on items not covered by the plan's in-network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to the cost of provider services or contact lenses. Retail prices may vary by location.
- Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Discounts are only available with network Providers.
- Members also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.evemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Plan Limitations/Exclusions:

- Allowances are one-time use benefits; no remaining balance.
- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Services provided as a result of any Worker's Compensation law.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Plano lenses and non-prescription sunglasses (except for 20% discount).
- Services or materials provided by major medical coverage under any other group benefit providing for vision care.
- Two pair of glasses in lieu of bifocals.
- Aniseikonic lenses.
- Discounts do not apply for benefits provided by other group benefit plans.
- Lost or broken materials are not covered.

Welcome to Surency Vision

Surency Vision is offered through Surency Life & Health Insurance Company ("Surency"). Claims processing, claims service and network administration for Surency Vision are handled through an agreement with EyeMed Vision Care, LLC.

Surency has been selected by your employer to provide your group vision coverage. We are pleased to bring these important benefits to you and any eligible dependents you have enrolled for coverage.

This Summary of Vision Plan Benefits describes the essential features of your group vision coverage. This Summary of Vision Plan Benefits is a summary of benefits only and does not bind Surency to any coverage. All benefits are paid according to the terms, conditions and provisions of your employer's Agreement with Surency, which is binding on all parties and supersedes all other written or oral communications.

Surency's Customer Service department can be reached at 316.462.3316 or toll free 866.818.8805. You may also access our network through our website at www.surency.com.

(When searching for a provider, please search the Access Network.)

Strong Provider Network

Surency Vision is proud to collaborate with EyeMed Vision Care to provide a network that offers quality, convenience and choice. EyeMed has one of the largest, most diverse networks in the nation, which includes both nationally recognized retail chains and independent private practitioners.

- Find convenient provider locations online at www.surency.com.
- Popular retail chains including...



LENSCRAFTERS®



Sears

PEARLE VISION®

Optical



OPTION #2

Summary of Vision Plan Benefits

U S D #260 - DERBY

Effective February 1, 2014

ANNUAL ALLOWANCES IN NETWORK OR OUT OF NETWORK

MATERIALS COVERED	IN NETWORK	OUT OF NETWORK	FREQUENCY
Frames, Lens & Options Package: <i>Any frame, lens and lens options available at provider locations</i>	\$200 Allowance for frame, lens and lens options, 20% off balance over \$200	\$200	Per Calendar Year
Contact Lenses: <i>(in lieu of frames, lens & options package)</i>	\$200 Allowance	\$200	Per Calendar Year

A child is eligible for coverage under the Plan if the child is under the age of twenty-six (26).

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

This is a Summary of benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.

Additional Value Added Savings:

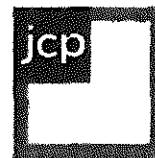
- Members will receive a 20% discount on items not covered by the plan's in-network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to the cost of provider services or contact lenses. Retail prices may vary by location.
- Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Discounts are only available with network Providers.
- Members also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-SLASER6.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Plan Limitations/Exclusions:

- Allowances are one-time use benefits; no remaining balance.
- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Benefits will not be provided for services or injuries or diseases related to your job to the extent you are covered or required to be covered by any Workers' Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under Workers' Compensation law, the policy will not pay those medical benefits that would have been payable in the absence of that settlement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Plano lenses and non-prescription sunglasses (except for 20% discount).
- Services or materials provided by major medical coverage under any other group benefit providing for vision care.
- Two pair of glasses in lieu of bifocals.
- Aniseikonic lenses.
- Discounts do not apply for benefits provided by other group benefit plans.
- Lost or broken materials are not covered.

***Surency Vision Provider Network***

Surency Vision is proud to collaborate with EyeMed Vision Care to provide a network that offers quality, convenience and choice. EyeMed has one of the largest, most diverse networks in the nation, which includes both independent private practitioners and nationally recognized retail chains:

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Sears
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APPENDIX F GROUP LIFE PLAN

This Appendix F contains the terms and conditions specific to the USD 260 - Derby Public Schools Group Life Plan provided under Section 4.03 of the Plan. Unless otherwise altered by the terms of this Appendix F, the terms and conditions of the Plan are incorporated into and made applicable to this Group Life Plan.

Section F1.01 Eligibility / Plan Entry Dates. The eligibility conditions and the Group Life Plan entry dates are the same as those for the Plan.

Section F1.02 Group Life Insurance. Life insurance benefits under this Group Life Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("The Guardian Life Insurance Company of America Group Contract") between The Guardian Life Insurance Company of America ("Guardian") and the Employer (Group No. 569620). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Guardian. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Group Life Plan shall be determined from the Guardian Group Contract. The Participant shall bear fully any and all risk of Guardian's insolvency.

Section F1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Guardian Group Contract. Under the terms of the Group Contract, Guardian may change the premiums from time to time. The Employer will pay 100% of the monthly premium cost.

Section F1.04 Entry into the Group Life Plan. An Eligible Employee shall automatically become a Participant in this Group Life Plan on the date the Eligible Employee becomes a Participant in the Plan. An election to participate in this Group Life Plan is neither necessary nor required.

Section F1.05 Claims Administration. Guardian will act as Claims Administrator with respect to any Claim for benefits under this Group Life Plan. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims in accordance with the terms of the Guardian Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section F1.06 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;

- (c) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (d) The date on which this Group Life Plan terminates.

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**INSERT GROUP LIFE
PLAN POLICY HERE**

APPENDIX G VOLUNTARY LIFE PLAN

This Appendix G contains the terms and conditions specific to the USD 260 - Derby Public Schools Voluntary Life Plan provided under Section 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix G, the terms and conditions of the Plan are incorporated into and made applicable to this Voluntary Life Plan.

Section G1.01 Eligibility / Plan Entry Dates. The eligibility conditions and the Voluntary Life Plan entry dates are the same as those for the Plan.

Section G1.02 Voluntary Life Insurance. Life insurance benefits under this Voluntary Life Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("The Guardian Life Insurance Company of America Group Contract") between The Guardian Life Insurance Company of America ("Guardian") and the Employer (Group No. 569620). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Guardian. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Voluntary Life Plan shall be determined from the Guardian Group Contract. The Participant shall bear fully any and all risk of Guardian's insolvency.

Section G1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Guardian Group Contract. Under the terms of the Group Contract, Guardian may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on an after-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section G1.04 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Group Contract. Under that agreement, Guardian may change the premiums from time to time. The Employer shall increase each Eligible Employee's monthly base salary by an amount equal to the then current monthly premium cost. Premiums shall then be paid by Participants on an after-tax basis.

Section G1.05 Election to Participate. A Participant who desires to receive life insurance benefits coverage under this Voluntary Life Plan must elect to participate in this Voluntary Life Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive life insurance benefits under this Voluntary Life Plan, the Employer will not provide him or her with any life insurance coverage.

Section G1.06 Payment of Premium. A Participant who has elected to participate in this Voluntary Life Plan may pay the applicable premium on an after-tax basis by authorizing a payroll deduction in the amount of the applicable premium.

Section G1.07 Claims Administration. Guardian will act as Claims Administrator with respect to any Claim for benefits under this Voluntary Life Plan. Guardian has been delegated full discretionary authority to make all determinations regarding the

administration and payment of such benefit Claims in accordance with the terms of the Guardian Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section G1.08 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Voluntary Life Plan terminates.

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**INSERT VOLUNTARY LIFE
PLAN POLICY HERE**

APPENDIX H

SHORT TERM DISABILITY PLAN

This Appendix H contains the terms and conditions specific to the USD 260 - Derby Public Schools Short Term Disability Plan that may be elected under Section 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix H, the terms and conditions of the Plan are incorporated into and made applicable to this Short Term Disability Plan.

Section H1.01 Eligibility / Plan Entry Dates. The eligibility conditions and the Short Term Disability Plan entry dates are the same as those for the Plan.

Section H1.02 Short Term Disability Benefits. Short term disability benefits under this Short Term Disability Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("The Guardian Life Insurance Company of America Group Contract") between The Guardian Life Insurance Company of America ("Guardian") and the Employer (Group No. 569620). The provisions of that group contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Guardian. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Short Term Disability Plan shall be determined from the Guardian group contract. The Participant shall bear fully any and all risk of Guardian's insolvency.

Section H1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Guardian group contract. Under the terms of the group contract, Guardian may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on an after-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section H1.04 Election to Participate. A Participant who desires to receive short term disability coverage under this Short Term Disability Plan must elect to participate in this Short Term Disability Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive short term disability coverage under this Short Term Disability Plan, the Employer will not provide him or her with any short term disability coverage.

Section H1.05 Payment of Premium. A Participant who has elected to participate in this Short Term Disability Plan may pay the applicable premium on an after-tax basis by authorizing a payroll deduction in the amount of the applicable premium.

Section H1.06 Claims Administration. Guardian will act as Claims Administrator with respect to any Claim for benefits under this Short Term Disability Plan. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims in accordance with the terms of the Guardian group contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section H1.07 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Short Term Disability Plan terminates.

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**INSERT SHORT TERM DISABILITY
PLAN POLICY HERE**

APPENDIX I AFLAC PRE-TAX PLAN

This Appendix I contains the terms and conditions specific to the USD 260 - Derby Public Schools AFLAC Pre-Tax Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix I, the terms and conditions of the Plan are incorporated into and made applicable to the AFLAC Pre-Tax Plan.

Section I1.01 Eligibility / Plan Entry Dates. The eligibility conditions and the AFLAC Pre-Tax Plan entry dates are the same as those for the Plan.

Section I1.02 Benefits Provided under Individual Policies. Under the AFLAC Pre-Tax Plan, the Participant may choose to receive benefits under one or more of the following policies of insurance:

- (a) *Critical Illness Plan.* Benefits under this Critical Illness Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.
- (b) *Accident Plan.* Benefits under this Accident Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.
- (c) *Hospital Indemnity Plan.* Benefits under this Hospital Indemnity Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

Section I1.03 Obligation to Pay Benefits. The Employer makes no promise and shall have no obligation to provide or pay benefits under these individual policies from its own assets. The rights and conditions with respect to the benefits payable under this AFLAC Pre-Tax Plan shall be determined from each individual AFLAC policy. The Participant shall bear fully any and all risk of AFLAC's insolvency.

Section I1.04 Cost of Coverage. The Participant's monthly premiums are determined by AFLAC pursuant to the terms of the policy or policies issued by AFLAC to the Participant. Under the terms of those policies, AFLAC may have the right to change the amount of the applicable premium from time to time. The Participant must pay the entire cost of the monthly premium for coverage on a pre-tax basis.

Section II.05 Election to Participate. A Participant who desires to receive benefits under one or more of the individual policies listed in Section II.02 above must elect to participate in this AFLAC Pre-Tax Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to participate, the Employer will not provide him or her with any benefits under this Plan.

Section II.06 Payment of Premium. A Participant who has elected to participate in this AFLAC Pre-Tax Plan must pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan.

Section II.07 Claims Administration. AFLAC will act as Claims Administrator with respect to any Claim for benefits under this AFLAC Pre-Tax Plan. AFLAC has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims, in accordance with the terms of the individual policy. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section II.08 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this AFLAC Pre-Tax Plan terminates.

INSERT AFLAC PLAN POLICY HERE

APPENDIX J LEGAL SERVICES PLAN

This Appendix J contains the terms and conditions specific to the USD 260 - Derby Public Schools Legal Services Plan provided under Section 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix J, the terms and conditions of the Plan are incorporated into and made applicable to this Legal Services Plan.

Section J1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Plan entry dates are the same as those for the Plan.

Section J1.02 Legal Services Plan. Benefits under this Legal Services Plan are identical to those described in, and shall be paid pursuant to, the terms of the contract between LegalShield and the Employer. The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by LegalShield. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Legal Services Plan shall be determined from the contract. The Participant shall bear fully any and all risk of LegalShield's insolvency.

Section J1.03 Life Events Legal Services Available. The following life event services are available through this Legal Services Plan, which is available to you:

- (a) Consultation on unlimited number of issues;
- (b) Attorneys will write letters or make phone calls to resolve issues;
- (c) Any contract/document up to 10 pages will be reviewed to protect your rights;
- (d) Last will and testament, living will and health care power of attorney with yearly updates;
- (e) Representation on any moving traffic violations nationwide, attorney fight to keep points off driving record and keep insurance rates down;
- (f) Attorney will represent member or family if charged criminally from an accident with no attorney fees;
- (g) Trial defense schedule of hours if the member or Spouse is sued;
- (h) Representation by a tax attorney if member is audited on personal tax return; and
- (i) 24 hour access in the event of a legal emergency, injury accident, warrant, or member being questioned, arrested, detained, etc.

Section J1.04 Identity Theft Shield Services Available. The following identity theft ("IDT") services are available through this Legal Services Plan, which is available to you:

- (a) Credit reports for member and Spouse;
- (b) Credit monitoring on a daily basis, all credit reports sent monthly; and
- (c) Restoration services for all areas of IDT including the 5 major areas: Financial, Criminal, Medical, Driver's License, and Social Security.

Section J1.05 Safeguard for Minors Services Available. The following safeguard for minors services are available through this Legal Services Plan, which is available to you:

- (a) Credit monitoring for the existence of a credit file; and
- (b) Restoration services for all areas of IDT including the 5 major areas: Financial, Criminal, Medical, Driver's License, and Social Security.

Section J1.06 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Group Contract with LegalShield. Under the terms of the Group Contract, LegalShield may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on an after-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section J1.07 Claims Administration. LegalShield will act as Claims Administrator with respect to any claim for benefits under this Legal Services Plan. LegalShield has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims in accordance with the terms of the Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section J1.08 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (d) The date on which this Legal Services Plan terminates.

**INSERT LEGAL PLAN
POLICY HERE**

APPENDIX K

3-in-1 PLAN

This Appendix K contains the terms and conditions specific to the USD 260 - Derby Public Schools 3-in-1 Plan (includes accident, critical illness, and hospital coverage) that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix K, the terms and conditions of the Plan are incorporated into, and made applicable to, this 3-in-1 Plan.

Section K1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the 3-in-1 Plan entry dates are the same as those for the Plan.

Section K1.02 3-in-1 Benefits. 3-in-1 benefits under this 3-in-1 Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Reliance Standard Life Insurance Company Group Contract") between Reliance Standard Life Insurance Company ("Reliance") and the Employer (Group No. accident - VAI 826285; critical illness - VCI801194; hospital - VHI000071). The provisions of that group contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Reliance. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this 3-in-1 Plan shall be determined from the Reliance Group Contract. The Participant shall bear fully any and all risk of Reliance's insolvency.

Section K1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Reliance Group Contract. Under the terms of the Group Contract, Reliance may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section K1.04 Election to Participate. A Participant who desires to receive accident, critical illness, and hospital coverage under this 3-in-1 Plan must elect to participate in this 3-in-1 Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive accident, critical illness, and hospital coverage under this 3-in-1 Plan, the Employer will not provide him/her with any accident, critical illness, and hospital coverage.

Section K1.05 Payment of Premium. A Participant who has elected to participate in this 3-in-1 Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement.

Section K1.06 Claims Administration. Reliance will act as Claims Administrator with respect to any Claim for benefits under this 3-in-1 Plan. Reliance has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims in accordance with the terms of the Reliance Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section K1.07 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

- (a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant’s termination of employment with the Employer;
- (b) The date on which the Participant’s election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this 3-in-1 Plan terminates.

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INSERT 3-IN-1 PLAN POLICY HERE

**SPECIAL COVID-19 PLAN AMENDMENT
FOR HIPAA SPECIAL ENROLLMENT RIGHTS**

USD 260 - DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN

This Amendment is made by USD 260 - Derby Public Schools, (the "Employer"), as Plan Sponsor of the USD 260 - Derby Public Schools Welfare Benefit Plan (the "Plan"), pursuant to the authority delegated to the Employer in Section 10.01 of the Plan:

WITNESSETH:

WHEREAS, the Plan provides certain welfare benefit plans to Eligible Employees on a pre-tax basis;

WHEREAS, when Eligible Employees elect a pre-tax benefit, according to Internal Revenue Service ("IRS") rules, he/she must keep that election for the entire Plan Year unless he/she experiences a qualifying election change event;

WHEREAS, Eligible Employees have HIPAA special enrollment rights upon the occurrence of certain events, giving them either 30 or 60 days to specially enroll in the Medical Plan, depending on the type of event and measured from the date of the event;

WHEREAS, Section 5.07(c) of the Plan currently permits an Eligible Employee who experiences a HIPAA special enrollment event to make a corresponding election change within either 30 or 60 days of the event in order to pay for any increase or decrease in premium cost on a pre-tax basis;

WHEREAS, in response to the Coronavirus Disease 2019 ("COVID-19") pandemic, the IRS and Department of Labor ("DOL") have directed that group health plans permit Eligible Employees to exercise a HIPAA special enrollment right during a period *longer than the current 30 or 60 day period*. The extended period to exercise a HIPAA special enrollment right runs from March 1, 2020, until 30 or 60 days (depending on the event) beyond the end of the Outbreak Period (defined as the period from March 1, 2020 until 60 days after the declared end of the national state of emergency (or such other date announced by the IRS and DOL)); and

WHEREAS, the Employer desires to temporarily permit those employees who exercise a HIPAA special enrollment right *more than 30 or 60 days after the qualifying event* the ability to pay for the extra cost of such coverage on a pre-tax basis throughout the expanded period in which the IRS has allowed the election change to be made as a result of the COVID-19 pandemic.

NOW, THEREFORE, effective March 1, 2020, Section 5.07(c) of the Plan shall be amended to read as follows:

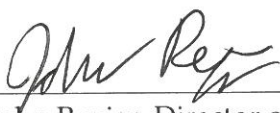
Status Change Form. Each Participant must complete a status change form and submit such form to the Plan Administrator no later than 60 days after the end of the Outbreak Period if exercising a HIPAA special enrollment right under (a)(i) or (a)(ii) above, or no later than 30 days after the end of the Outbreak Period if

exercising a special enrollment right under (a)(iii) or (a)(iv) above. The Outbreak Period is the period from March 1, 2020 until 60 days after the national state of emergency ends due to the COVID-19 pandemic.

FURTHER, that this Amendment shall expire 30 (or 60, as applicable) days after the end of the Outbreak Period.

IN WITNESS WHEREOF, the Employer has executed this Special COVID-19 Plan Amendment for HIPAA Special Enrollment Rights as evidenced by the signature affixed hereto of its duly authorized officer, on this _____ day of _____, 2020.

USD 260 - Derby Public Schools

By:  _____
John Regier, Director of Finance

2021 AMENDMENT

USD 260 DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN

This Amendment is made by USD 260 – Derby Public Schools in accordance with the provisions of the USD 260 Derby Public Schools Welfare Benefit Plan (the “**Plan**”):

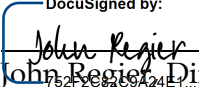
WITNESSETH:

WHEREAS, the Plan document that was effective on January 1, 1980.

WHEREAS, effective as January 1, 2021, USD 260 – Derby Public Schools hereby amends the Plan by amending pages 2.2, 3.2, A-1, A-2, C-7, and D-6 as reflected on the attached “redlined” pages.

USD 260 – Derby Public Schools directs that replacement pages reflecting the changes made by this Amendment be prepared and inserted into the Plan document at the appropriate place or places in place of those pages containing out-of-date language so that the Plan document will remain current and up-to-date.

IN WITNESS WHEREOF, the Director of Finance has executed this Amendment as evidenced by the signature affixed hereto of its duly authorized officer, on 4/1/2021.

By:  _____
John Register, Director of Finance

Section 2.10 “Effective Date” means the original date on which this Plan took effect, which date is January 1, 1980; provided, however, that if this Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.11 “Election Change Event” means an event which would allow a Participant to change the Participant’s elections during a Plan Year, subject to the requirements of Article V and as set forth in more detail in Sections 5.06 through 5.15.

Section 2.12 “Eligible Employee” means an Employee, other than a Temporary Employee, actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding twenty (20) hours per week, subject, however, to the following:

(a) Special Rules:

- (i) *Seasonal Employees and Substitutes.* Seasonal Employees and Substitute Teachers are not Eligible Employees under this Plan;
- (ii) *Status During Leaves of Absence.* An Employee’s status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer; during an unpaid leave of absence not to exceed the end of the month, or, if the FMLA is applicable to the Employer, during a leave of absence taken pursuant to the FMLA provided, however, any period of unpaid leave shall run concurrently with any FMLA leave;
- (iii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as “unpaid leave” for purposes of plan eligibility. However, nothing in this subsection shall preclude a Participant on FMLA leave from maintaining eligibility during such FMLA leave;
- (iv) *Special Rule for Employees in AmeriCorp.* Eligible Employees who are in the AmeriCorp program will not be eligible for Health FSA, DCAP, [Group Life Plan](#), Voluntary Life Plan, or Short Term Disability Plan that are provided under the Plan;
- (v) *Status During Military Service.* An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less; and
- (vi) *Medical, Dental, and Vision Plans.* An Eligible Employee who is participating in the Medical, Dental, and/or Vision Plans and who terminates employment with the Employer before the end of the month will continue to participate in this Plan for purposes of participating in the Medical, Dental, and/or Vision Plans on a pre-tax basis through the end of the month in which the termination occurs.

benefits under a Group Health Plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). If the Participant is a participant in the Health FSA, additional rules may apply to the Participant's coverage under the Health FSA as set forth in the Appendix for the Health FSA.

- (b) *Options for Payment of Participant's Share of the Premium.* If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one or more of the following ways:
- (i) The Participant may pay his/her share of the premiums with after-tax dollars while on leave (or with pre-tax dollars to the extent the Employee receives Compensation during the leave).
 - (ii) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.
- (c) *Return from FMLA Leave.* If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that the Participant was participating in the Plan prior to his/her leave, or as otherwise required by the FMLA.
- (d) *Failure to Pay Premiums While on FMLA Leave.* If the Participant fails to remit his/her premium payments within thirty (30) days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate the Participant's coverage retroactive to the date the unpaid premium payment was due.

APPENDIX A
MEDICAL PLAN

This Appendix A contains the terms and conditions specific to the USD 260 – Derby Public Schools Medical Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix A, the terms and conditions of the Plan are incorporated into and made applicable to this Medical Plan.

Section A1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.

Section A1.02 Medical Benefits. Benefits under this Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract (“Blue Cross Blue Shield Group Contract”) between Blue Cross Blue Shield (“BCS”) and the Employer (Group No. 204150789). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by BCBS. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Medical Plan shall be determined from the BCBS Group Contract. The Participant shall bear fully any and all risk of BCBS’s insolvency.

Section A1.03 Cost of Coverage. The Participant’s monthly premiums are determined pursuant to the BCBS Group Contract. Under the terms of the Group Contract, BCBS may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant. If money is returned in any form by BCBS, including but not limited to a rebate or proceeds from demutualization, the Plan Administrator shall apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section A1.04 Election to Participate. A Participant who desires to receive medical insurance coverage under this Medical Plan must elect to participate in this Medical Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive medical coverage under this Medical Plan, the Employer will not provide him or her with any medical insurance coverage.

Section A1.05 Payment of Premium. A Participant who has elected to participate in this Medical Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section A1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) ineligible employees as defined in Section 2.12(b) of the Plan, all premiums must be paid through pre-tax salary reductions.

Section A1.06 Continuation of Coverage. An individual who will lose coverage under this Medical Plan may have the right to continue coverage under this Medical Plan as described in Article VIII.

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Section A1.07 Children Subject to a NMSN. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Medical Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such NMSN.

Section A1.08 Claims Administration. BCBS will act as Claims Administrator with respect to any claim for benefits under this Medical Plan. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

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Section A1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Medical Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Medical Plan if and to the extent such individual elects continuation of benefits under the rules in Section A1.06.

Section A1.10 Character of Benefits Provided. This Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular medical service may not be eligible for reimbursement under this Medical Plan does not mean that a Participant or other person who is covered under this Medical Plan should not receive that service.

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ARTICLE C-III CLAIMS PROCEDURE

Section C3.01 Submission of Claims. A Participant desiring to be reimbursed for medical expenses must apply for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his or her Health FSA through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section C3.03. Subject to Section C4.01 of this Plan, a Participant must submit the application for reimbursement for expenses incurred during a Plan Year before the end of the Run-Out Period, defined in Section C2.04. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

- (a) The amount, date incurred, and nature of each expense;
- (b) The name of the person, organization, or entity with whom the expense was incurred;
- (c) The name of the person for whom the expense was incurred;
- (d) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and
- (e) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other statements or documents that the Claims Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Section C3.02 Claims Administration. Surency Life & Health will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Surency Life & Health is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

Section C3.03 Electronic Payment Card Reimbursements. If the funds in a Health FSA are accessible by electronic debit card a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. A debit card that is presented as payment for a medical expense and denied at the point-of-sale (i.e., when the service or item is provided) does not constitute an initial claim denial under these procedures.

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- _____ (b) The name of the person, organization, or entity to which the expense was or is to be paid;
- (c) The signature of the daycare provider; and
- (d) Such other information as the Claims Administrator may from time to time require.

Such application shall be accompanied by bills, invoices, receipts, or other statements or certifications showing the amounts of such expenses, together with any additional documentation which the Employer may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Claims may be filed by the Participant or by the Participant's duly authorized representative. Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

Section D3.03 Claims Decisions. Surency Life & Health will act as Claims Administrator with respect to any Claims for benefits under this DCAP. Surency Life & Health has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

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Section D3.04 Electronic Payment Card Reimbursements. If the funds in a DCAP are accessible by electronic debit card a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance.

Section D3.05 Limitation on Reimbursements with Respect to Certain Participants. No more than twenty five percent (25%) of the total amounts reimbursed from all dependent care assistance accounts maintained by all Participants under this DCAP during any Plan Year may be reimbursed with respect to the class of individuals who own more than five percent (5%) of the stock of the Employer (or their Spouses or dependents). Notwithstanding any other provision of this DCAP, the Claims Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated employee (within the meaning of Code § 414(g)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with the restriction described in the preceding sentence or with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section D2.08 above.

Section D3.06 Time Frame for Deciding Claims. The Claim for reimbursement shall be approved or denied within a reasonable period (but no later than 90 days) after receipt of the Claim by the Claims Administrator. The initial 90-day period begins at the time the Claim is filed whether or not all the necessary information for determining the Claim is provided at that time.

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USD 260 - DERBY PUBLIC SCHOOLS

WELFARE BENEFIT PLAN

Summary Plan Description

USD 260 - DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
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SUMMARY PLAN DESCRIPTION

USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN

USD 260 – Derby Public Schools (“Employer”) maintains the USD 260 – Derby Public Schools Welfare Benefit Plan (the “Plan”) for the exclusive benefit of, and to provide benefits to, its Eligible Employees, their legal Spouses, and their eligible dependents.

This Summary Plan Description (“SPD”) describes the basic features of the Plan, how the Plan operates, and the benefits that can be purchased through the Plan. This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. *If there is a conflict between the plan documents and this SPD, the plan documents will control.*

(1) General Information

- (a) *Type of Plan.* The Plan is a cafeteria plan. The Employer has assigned number 501 as the Plan Number for the Plan.
- (b) *Pre-Tax Benefits.* Participants in the Plan may reduce their salary on a pre-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:
 - (i) USD 260 – Derby Public Schools Medical Plan (“Medical Plan”);
 - (ii) USD 260 – Derby Public Schools Dental Plan (“Dental Plan”);
 - (iii) USD 260 – Derby Public Schools Health Flexible Spending Account Plan (“Health FSA”);
 - (iv) USD 260 – Derby Public Schools Dependent Care Assistance Plan (“DCAP”);
 - (v) USD 260 – Derby Public Schools Vision Plan (“Vision Plan”);
 - (vi) USD 260 – Derby Public Schools AFLAC Pre-Tax Plan (“AFLAC Pre-Tax Plan”); and/or
 - (vii) USD 260 – Derby Public Schools 3-in-1 Plan (“3-in-1 Plan”).

Each of the above Pre-Tax Benefits is governed by a plan document. Please refer to such document for information regarding specific terms and conditions associated with each plan. This SPD serves as the summary plan description for each of these Pre-Tax Benefits. A summary of each of these plans is provided later in this SPD.

The amount by which your salary is reduced to purchase benefits, and any benefits paid to you under these Pre-Tax Benefits, will not be included in your taxable income for federal income tax purposes and is not subject to FICA taxes.

- (c) *After-Tax Benefits.* Participants in the Plan may reduce their salary on an after-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:
- (i) USD 260 – Derby Public Schools Voluntary Life Plan (“Voluntary Life Plan”);
 - (ii) USD 260 – Derby Public Schools Short Term Disability Plan (“Short Term Disability Plan”); and/or
 - (iii) USD 260 – Derby Public Schools Pre-Paid Legal Plan (“Pre-Paid Legal Plan”).

This SPD serves as the summary plan description for each of these plans. A summary of each of these plans is provided later in this SPD.

- (d) *Employer Paid Benefit.* The USD 260 – Derby Public Schools Group Life Plan (“Group Life Plan”) is an Employer Paid Benefit that is available through this Plan.

This SPD serves as the summary plan description for each of these plans. A summary of each of these plans is provided later in this SPD.

- (e) *Employer.* The name, address, telephone number, and Federal tax identification number of the Employer are:

**USD 260 – Derby Public Schools
1550 E. Walnut Grove Road
Derby, Kansas 67037
(316) 788-8420
EIN: 48-0727674**

- (f) *Plan Administrator.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Department of Labor and the Internal Revenue Service. The Plan Administrator is vested with full discretionary authority to interpret, construe, and carry out the provisions of the Plan, and to render decisions on the administration of the Plan, including any factual and legal determinations as to whether an individual is eligible to participate in the Plan. The Plan Administrator has the authority to take such corrective action as it might consider to be appropriate in the event that an error in administering the Plan has taken place. For example, if there is a failure to deduct the correct amount of a Participant’s election, the Plan Administrator has the authority to deduct an overpayment from future compensation payable to the Participant and/or otherwise recover the amount that is owed.
- (g) *Service of Process.* The name of the person designated as the Agent for Service of Legal Process is Heather Bohaty, whose address is the same as the Employer’s address.

- (h) *Spouse.* When the word “Spouse” is used in this SPD, it means a person of the same or opposite sex to whom you are legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which you currently reside. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a “Spouse” for purposes of the Plan if (i) his/her marriage to you has been terminated by a court having jurisdiction over you or the individual or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.
- (i) *Plan Year.* The Plan Year is the calendar year.

(2) Participation in the Plan

You will automatically become a Participant in the Plan on your plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

- (a) *Eligibility Conditions.* To be eligible to participate in the Plan, the following conditions must be met:
 - (i) *Employee.* You must be an individual employed by the Employer;
 - (ii) *Regularly Scheduled Hours per Week.* Your regularly scheduled workweek must ordinarily equal or exceed twenty (20) hours per week. For purposes of the Plan, this is considered to be “full-time”;
 - (iii) *Special Rule for Employees in AmeriCorp.* If you are an Eligible Employee who participates in the AmeriCorp program, you will not be eligible for Health FSA, DCAP, Group Life Plan, Voluntary Life Plan, or Short Term Disability Plan that are provided under the Plan; and
 - (iv) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (A) covered under a collective bargaining agreement; (B) classified as a “seasonal” employee; (C) classified as a “substitute teacher;” (D) classified on the Employer’s payroll records as a “leased” employee; or (E) for purposes of participating in this Plan (but not, unless otherwise provided, for purposes of participating on an after-tax basis in any underlying Benefit Package Option), an individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or is treated as a partner under Section 1372 of the Code.

(b) *Plan Entry Date.*

- (i) *General Rule.* If you are an Eligible Employee, you will become a Participant on the first day of the month following thirty (30) days of continuous, active employment as an Eligible Employee, even if you do not choose to purchase benefits under one or more of the Pre-Tax Benefits and/or After-Tax Benefits.

EXAMPLE #1: You begin working as a full-time employee on March 15. You complete thirty (30) days of employment with the Employer on April 14. You will become a Participant in the Plan on May 1.

- (ii) *Special Rule for Employees in AmeriCorp Program.* If you are an Eligible Employee who participates in the AmeriCorp program, you will enter the Plan on the first day of the month following your date of hire. This Special Rule applies despite the General Rule set forth in 2(b)(i) above.

(c) *Termination of Participation.* Once you become a Participant, you will continue to be a Participant as long as you continue to satisfy the conditions for being an Eligible Employee, as summarized above. If one or more of these conditions is not met, you will cease to be a Participant, unless a special rule applies. The special rules that might apply are summarized below.

- (i) *Special Rule for Leaves of Absence.* If the number of hours that you are regularly scheduled to work each week falls below the minimum number required for you to participate in the Plan, you may still continue to participate in the Plan if you are on (A) a paid leave approved by the Employer; (B) unpaid leave under the Family and Medical Leave Act ("FMLA") if the FMLA is applicable to the Employer; provided, however, any period of unpaid leave shall run concurrently with any FMLA leave; or (C) unpaid leave through the end of the month.
- (ii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as "unpaid leave" for purposes of plan eligibility. However, nothing in this subsection shall preclude you, if you are on FMLA leave from maintaining eligibility during such FMLA leave.
- (iii) *Special Rule for Military Service.* If you enter active service in the armed forces of any country, you will not be eligible to participate in the Plan unless your service is temporary active service of two (2) weeks or less.
- (iv) *Special Rule for Certain Pre-Tax Benefits.* If you are participating in a Pre-Tax Benefit and your employment is terminated before the end of a pay period or the end of the month, your participation in the Plan may continue through the end of the pay period and/or the month (depending on the underlying Pre-Tax Benefit).

EXAMPLE: You participate in the Medical Plan. You are paid on the 1st and 15th of each month. You terminate employment on July 5th. You will remain an Eligible Employee in the Plan for purposes of participating in the Medical Plan on a pre-tax basis through the end of the month.

(3) Pre-Tax Benefit Options – Participant Elections

To purchase benefits on a pre-tax basis through the Plan, you must make what is known as an “Election.” Once you have made an Election, you will not be able to change that Election until the next Plan Year, unless an exception applies. These rules are discussed in more detail below.

- (a) *How to make an Election.* To make an Election, you must complete a Salary Reduction Agreement and return the completed Agreement to the Plan Administrator. If you are changing an Election in the middle of a Plan Year, you may also be required to complete and return an Election Change form. The Plan Administrator may require the Salary Reduction Agreement or the Election Change form to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.
- (b) *When to make an Election.*
 - (i) *General Rule.* An Election for the next Plan Year must be made during the Annual Enrollment Period for that Plan Year. The Annual Enrollment Period will be announced by the Plan Administrator each year.
 - (ii) *Initial Election by New Participants.* If you are a newly Eligible Employee, an Election will normally need to be made prior to the date you enter the Plan as a Participant.
 - (iii) *Election Changes.* An Election change during the middle of a Plan Year must be made no later than thirty (30) days after the event that allows an Election change to be made, except that an Election change made in connection with certain HIPAA special enrollment rights may be made within sixty (60) days after the event as further described in (3)(d)(ii) below.
- (c) *Failure to make an Election.*
 - (i) *Failure to Make an Initial Election.* If you have never made an Election, you will not be able to purchase any benefits through the Plan on a pre-tax basis.
 - (ii) *Failure to Change Existing Election.* Once you have made an Election, a failure to complete a new salary reduction agreement for a subsequent Plan Year will be treated as a decision on your part to retain your existing Elections for the new Plan Year. However, if you have elected to put money into the Health FSA or DCAP, your Election for those plans will be reduced to zero dollars for any subsequent Plan Years.
- (d) *Election Changes.* An Election may not be changed in the middle of a Plan Year unless you qualify for one of the exceptions listed below. All Election changes must be approved by the Plan Administrator. In approving or denying an Election change, the Plan Administrator may rely on the terms of the Plan, Internal Revenue Service Regulations, and informal guidance from the Internal Revenue Service (the “IRS”).

You may change an Election in the middle of a Plan Year in the following circumstances (and subject to the other rules of the Plan):

- (i) *Change in Status.* If there is a “change in status” and the Election change is consistent with the “change in status.” The following events may constitute a “change in status”:
 - (A) A change in your marital status;
 - (B) A change in the number of your dependents;
 - (C) A change in the employment status of yourself, your Spouse, or your dependent. This may include starting a new job, leaving an old job, taking an unpaid leave of absence, or returning from an unpaid leave of absence. It may also include a change in the number of hours that you, your Spouse, or your dependent are regularly scheduled to work, but only if the change in hours affects your eligibility for benefits under the Plan or any of the other Benefit Plans or your Spouse’s or dependent’s eligibility under a benefit plan of their employer;
 - (D) One of your dependents satisfies, or ceases to satisfy, the eligibility requirements for a dependent under a Benefit Plan;
 - (E) A change in residence for yourself, your Spouse, or your dependent if it affects that person’s eligibility for benefits; and/or
 - (F) You enroll in a Qualified Health Plan through an Exchange / Health Insurance Marketplace (the “Marketplace”) established pursuant to the Patient Protection & Affordable Care Act by virtue of having become eligible for a Special Enrollment Period in the Marketplace or by having enrolled during the Marketplace’s annual open enrollment period. However, in order to make an election change on this basis, you (and any Spouse and/or dependents who are covered through you) must enroll in the Qualified Health Plan and have such coverage take effect no later than the day immediately following the day that your coverage under the Medical Plan is terminated.

Whether an Election change is consistent with the “change in status” will be determined by the Plan Administrator in accordance with IRS Regulations and prevailing IRS guidance.

- (ii) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), group health plans must provide a “special enrollment” period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth, or adoption. These individuals also include individuals who become eligible for

a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your "special enrollment" rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Although the normal deadline to make an election change is 30 days after the election change event took place, you have 60 days to enroll an individual using HIPAA special enrollment rights (and, if they are not already enrolled, other family members, including yourself) if the election change event is related to the individual becoming eligible for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.

- (iii) *Change in Coverage of Your Spouse or Dependent.* If there is a change in the coverage of your Spouse or your dependent and that coverage is obtained through the cafeteria plan of another employer, you may make a "corresponding" Election change. For this exception to apply, one of the following conditions must be met: (A) The plan year of the other employer's cafeteria plan is different than the Plan Year of the Plan; or (B) the cafeteria plan of the other employer permits only those Election changes that are authorized under IRS regulations. The Plan Administrator will decide in its discretion and in accordance with prevailing IRS guidance whether a requested change is on account of and corresponds with the change made under the plan of the other employer.
- (iv) *EXAMPLE:* You have elected to provide medical coverage for your family under the Employer's Medical Plan. Your Spouse is employed by a different employer. During open enrollment for the cafeteria plan of that employer, your Spouse elects "family coverage" under the medical plan of that employer. The plan year of that employer is different than the plan year of your Employer. Under this exception, you may discontinue your Election to pay for family coverage on a pre-tax basis through the Plan.
- (v) *Loss of Governmental / Educational Institution Group Health Coverage (Does not apply to the Health FSA or DCAP).* If you, your Spouse, or your dependent loses group health coverage and the coverage was sponsored by a governmental or educational institution, you may make an Election change to add coverage for the persons who are losing coverage. For purposes of this provision, group health coverage sponsored by a governmental or educational institution includes a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government or a tribal organization, a state health benefits risk pool, or a foreign government health plan.
- (vi) *"Significant" Curtailment in Coverage (Does not apply to the Health FSA).*
 - (A) *Without Loss of Coverage.* If coverage under a plan is "significantly curtailed," but not lost, you may change your Election to elect coverage under another benefit option that provides similar coverage. Coverage under a plan is "significantly curtailed" only if there is an overall reduction in the coverage provided to Participants in the plan.

- (B) *With Loss of Coverage.* If coverage under a plan is “significantly curtailed” and that curtailment constitutes a “loss of coverage” for you, your Spouse, or your dependent, you may change your Election to elect coverage under another benefit option that provides similar coverage. If no similar benefit option is available, you may elect to drop coverage. For purposes of this provision, a “loss of coverage” means a complete loss of coverage under the benefit option. This includes the elimination of a benefit option, the loss of coverage under an option due to an individual reaching an overall lifetime or annual coverage limit, a substantial decrease in the medical care providers available under the option, or a reduction in the benefits for a specific type of medical condition or treatment for which you, your Spouse, or your dependent is currently receiving treatment.
- (C) *Determinations to be Made by the Plan Administrator.* The Plan Administrator will decide in its discretion, and in accordance with prevailing IRS guidance, whether a curtailment is “significant,” whether a curtailment represents a “loss of coverage” with respect to a particular individual, and whether a substitute benefit option provides “similar coverage.”
- (vii) *Addition or Improvement of a Benefit Option (Does not apply to the Health FSA).* If a benefit option is added in the middle of a Plan Year or if coverage under an existing benefit option is significantly improved, you may make an Election change to add that option.
- (viii) *FMLA Leave.* If you take a leave of absence under the FMLA, you may change your Election for coverage under a plan. You may also be able to change your Election under the “change in status” exception discussed above.
- (ix) *To Comply with a Judgment, Decree or Order.* If you are required to provide medical coverage for a dependent child pursuant to a judgment, decree or order, you may change your Election to pay for the increased cost of the coverage. If you are already providing coverage and a judgment, decree or order requires someone else to provide coverage, you may change your Election to reflect the decreased cost of coverage. *However*, before you are allowed to drop coverage, you may be required to provide proof that other coverage for the child is actually being provided.
- (x) *Entitlement to Medicare / Medicaid.* If you, your Spouse, or your dependent becomes entitled to Medicare or Medicaid, you may change your Election to reflect the decreased cost of coverage under the employer’s group health plan. If you, your Spouse, or your dependent loses your/their entitlement to Medicare or Medicaid, you may increase your Election to reflect the increased cost of coverage under the employer’s group health plan.

- (xi) *Significant Change in Cost of Coverage (Does not apply to the Health FSA).* If your share of the premium for coverage under a benefit option increases by a significant amount, you may increase your Election to reflect the increased cost or you may elect to be covered under another benefit option (if any) providing similar coverage. If similar coverage is not available, you may drop your coverage all together.

If your share of the premium for coverage under a benefit option decreases by a significant amount, you may decrease your Election by a corresponding amount or, if you are not currently enrolled in that benefit option, you may elect to become covered under that benefit option.

Whether there has been a “significant” change in cost and whether another benefit option provides “similar coverage” will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

In addition to the Election changes which you may make in the middle of a Plan Year, as summarized above, the Plan Administrator may automatically change the amount of your Election in the middle of a Plan Year if there is an “insignificant” change in the cost of the coverage you have elected. Whether there has been an “insignificant” change in cost will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

- (e) *Effective Date of Elections.*
 - (i) *Election Made During Annual Enrollment Period.* An Election made during the Annual Enrollment Period will be given effect as of the first day of the next Plan Year.
 - (ii) *Election Made in the Middle of a Plan Year.* An Election made in the middle of a Plan Year will be given effect as of the earliest administratively practicable date after a completed Election Change Form and Salary Reduction Agreement are received by the Plan Administrator. This includes both Election changes and the initial Elections made by new Participants. Under IRS regulations, Elections cannot be given retroactive effect. For example, although you can use pre-tax dollars to pay for future coverage, you cannot use pre-tax dollars to pay for coverage that has already been provided.
 - (iii) *Special Rule for HIPAA Special Enrollment Rights.* The only exception to this prohibition against retroactive election changes is for newborn children and newly adopted dependents who are enrolled in a group health plan pursuant to HIPAA “special enrollment” rights. Coverage that is retroactive to the date of their birth or adoption may be paid for on a pre-tax basis.
- (f) *Special Rule for Former Participants Rehired Within Thirty (30) Days of Termination.* If you are rehired within thirty (30) days after the date on which your employment was terminated, you will be reinstated in the Plan with the same Elections you had before your employment was terminated unless (i) you would be permitted to make an

Election change for some reason other than the change in your employment with the Employer or (ii) the Plan Year ended on or after the date your employment was terminated but before the date you were rehired.

- (g) *Special Rule for Health FSAs.* You may *not* change your Election under the Health FSA in the middle of a Plan Year except as follows:
- (i) You may begin to participate in the Health FSA if you are eligible, provided you are permitted to make an Election change under the rules summarized in Section 3(d) above;
 - (ii) You may increase your Election as long as you do not exceed the maximum election amount permitted under the Health FSA and provided you are permitted to make an Election change under the rules summarized in Section 3(d) above; or
 - (iii) You may decrease your Election, provided you are permitted to make an Election change under the rules summarized in Section 3(d) above; however, you may not reduce your election amount below the total amount you have already been reimbursed.

Example. During the Annual Enrollment Period, you make an Election of \$1,200 for your Health FSA for the Plan Year. To pay for this benefit, your salary is reduced by \$100 per month. Suppose that after three months, you have contributed a total of \$300 into your Health FSA, you have been reimbursed \$400, and you experience a qualifying election change event. You may change your election for the Plan Year to any amount equal to or greater than \$400.

Continuing with the above example, suppose you change your election amount to \$600 instead of \$1,200. Because you have already been reimbursed \$400, only \$200 will be available to you for reimbursement through the end of the Plan Year.

Except as set forth above, an Election with respect to the Health FSA may not be changed during the Plan Year once it has been made.

(4) After-Tax Benefit Option - Participant Elections

You may make and/or change your Elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such Election change will take effect on the earliest administratively practicable date after the request to change an after-tax Election is received by the Plan Administrator.

(5) Medical Plan

The Employer maintains a Medical Plan that pays benefits pursuant to the terms and conditions of a group contract with Blue Cross Blue Shield of Kansas ("BCBS"), 1133 SW Topeka Boulevard, Topeka, Kansas 66629-0001.

- (a) *Type of Plan.* The Medical Plan is a group health plan. The Medical Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Dates.* The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Medical Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Medical Plan entry date. **If you do not elect to participate in the Medical Plan, you will not receive any benefits under the Medical Plan.**
 - (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Medical Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the BCBS group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.
 - (ii) *HIPAA "Special Enrollment" Rights.* If you are declining enrollment in the Medical Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. Finally, if you become eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP), you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within sixty (60) days after you or your dependents become eligible for such assistance. Similarly, if you lose eligibility for Medicaid or SCHIP coverage, you have special enrollment rights in the Plan, provided you request enrollment within sixty (60) days after you or your dependents lose eligibility for Medicaid or SCHIP coverage.
- (d) *Plan Benefits.* If you elect to participate in the Medical Plan, benefits will be provided by the Employer pursuant to the terms and conditions of the group contract between the Employer and BCBS. This Medical Plan provides you and/or your dependents with comprehensive medical coverage. BCBS has prepared materials which explain the benefits under this Medical Plan in detail. If you have not received these materials from BCBS, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

- (e) *Obligation to Pay Benefits.* BCBS is solely obligated to pay for medical benefits provided under the BCBS group contract. The Employer makes no promise and will have no obligation to provide or pay for any benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Medical Plan are determined by BCBS and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.
- (g) *Medical Treatment.* The Medical Plan does not provide medical treatment or give medical advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate medical treatment.** The fact that some expense may not be eligible for reimbursement by the Medical Plan does not mean that you or your dependents should not have that treatment.
- (h) *Claims Procedures.* In the event you have a claim for benefits under the Medical Plan, you should follow the procedures outlined in the materials prepared by BCBS as applicable. The Plan Administrator, upon your request, will assist you in making these claims. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the applicable group contract.
- (i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Medical Plan at your primary residence (as provided to the claims administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.
- (j) *Termination of Coverage.* Your participation in the Medical Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date in which your election to participate expires;
 - (iii) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
 - (iv) The last day of the month in which you are no longer an Eligible Employee; or
 - (v) The day the Employer terminates the Medical Plan.

Your coverage for benefits under the Medical Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(6) Dental Plan

The Employer maintains a Dental Plan that pays benefits under an insurance contract with Delta Dental of Kansas ("Delta Dental"), P.O. Box 789769, Wichita, KS 67278.

- (a) *Type of Plan.* The Dental Plan is a group health plan. The Dental Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Dates.* The eligibility conditions and the Dental Plan entry dates are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Dental Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Dental Plan entry date. **If you do not elect to participate in the Dental Plan, you will not receive any benefits under the Dental Plan.**
 - (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Dental Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the Delta Dental group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.
- (d) *Plan Benefits.* If you elect to participate in the Dental Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a group contract between the Employer and Delta Dental. This Dental Plan provides you and/or your dependents with comprehensive dental coverage. Delta Dental has prepared materials which explain the benefits under this Dental Plan in detail. If you have not received these materials from Delta Dental, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Delta Dental is solely obligated to pay for the benefits provided under the Delta Dental group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Dental Plan are determined by Delta Dental and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.
- (g) *Dental Treatment.* The Dental Plan does not provide dental treatment or give dental advice. **It is your responsibility, in consultation with the dentists of your choice, to get appropriate dental treatment.** The fact that some expense may not be eligible for reimbursement by the Dental Plan does not mean that you or your dependents should not have that treatment.

- (h) *Claims Procedures.* In the event you have a claim for benefits under the Dental Plan, you should follow the procedures outlined in the materials prepared by Delta Dental as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Delta Dental has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Dental Plan at your primary residence (as provided to the claims administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.
- (j) *Termination of Coverage.* Your participation in the Dental Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date in which your election to participate expires;
 - (iii) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
 - (iv) The last day of the month in which you are no longer an Eligible Employee; or
 - (v) The day the Employer terminates the Dental Plan.

Your coverage for benefits under the Dental Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(7) Health Flexible Spending Account Plan

The Employer maintains a Health FSA that pays benefits out of the Employer's general assets.

- (a) *Type of Plan.* The Health FSA is a self-funded group health plan. The Health FSA is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan.
- (c) *Election to Participate in the Plan.* To become a Participant in the Health FSA, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the Health FSA, the Employer will not provide you with any benefits under the Health FSA.**

- (i) *Failure to Enroll When First Eligible.* As a general rule, if you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Health FSA until the next Annual Enrollment Period, in which case your enrollment will not take effect until the first day of the next Plan Year. However, if you experience an event that would allow an Election change under the terms of the Plan (see Section 3(d) of this SPD), you may enroll in the Health FSA in the middle of the Plan Year.
- (ii) *Election Changes Once Enrolled in the Health FSA.* Once you elect to participate in the Health FSA, you will be permitted to change your Election after the beginning of the Plan Year if you experience an event that would allow an Election change under the terms of the Plan (see Section 3(d) and (g) of this SPD). In general, you may begin participation or increase your Election amount for the remainder of the Plan Year. You are also permitted to decrease your Election amount provided, however, that the Election amount is not less than the amount you have already been reimbursed.

To determine the amount that you may be reimbursed for the remainder of the Plan Year, you should subtract the amount you have already been reimbursed from the new Election amount.

Example. During the Annual Enrollment Period, you elect \$1,200 for the Plan Year. You make monthly contributions of \$100 per month for 6 months (totaling \$600) and you are reimbursed \$900 during that 6 month period. Suppose you experience an election change event which would permit you to change your Election for the remaining 6 months of the Plan Year. You then request to decrease your election to \$600. You will not be permitted to make this change in your Election amount. This is because your total reimbursements to date (i.e., \$900) is greater than the new Election amount (i.e., \$600). You could, however, decrease your Election to \$1,000 for the remainder of the Plan Year. This is because your new Election amount is greater than the amount you have already been reimbursed (i.e., \$900). In the remaining 6 months of the year, you will be able to receive \$100 in future reimbursements.

- (d) *Special Rules Relating to FMLA Leave.* If you are a Participant in the Health FSA and you are taking or returning from FMLA leave, the following special rules apply to your participation in the Health FSA:
 - (i) *Taking FMLA Leave.* You may continue to participate in the Health FSA after you begin your FMLA leave by continuing to pay the applicable premium while you are on leave or by making such other arrangements for the payment of the applicable premiums as may be permitted under the Plan (see Section 19(b) of this SPD). You may also choose to discontinue your participation in the Health FSA once you begin your FMLA leave.
 - (ii) *Returning From FMLA Leave.* If you discontinued your participation in the Health FSA when you began your FMLA leave, you may choose to participate again once you return to work from your FMLA leave. If you want to resume your participation at the same coverage level that was in effect before your FMLA

leave, you will be required to pay the premiums that would have been due while you were on FMLA leave. If you do not want to make up the missed premiums, you may instead choose to resume coverage at a reduced level. In this event, the amount of coverage that you elected will be reduced by the percentage of the Plan Year that you were on FMLA leave. For example, if you had elected \$1,200 for the Plan Year and were on FMLA for two months, your annual Election would be reduced to \$1,000 under this alternative.

(e) *Effective Date of Election.* If you elect to participate in the Health FSA, your Election will take effect and you will become a Participant as follows:

- (i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a Participant as of the first day of the next plan year.
- (ii) *Election Made by A Newly Eligible Employee.* If you are a newly Eligible Employee, your Election will take effect when you become a Participant in the Plan.

EXAMPLE. You begin working as a full-time employee on March 15. You complete thirty (30) days of employment with the Employer on April 14. You timely elect to participate in the Health FSA. Your Election takes effect on May 1.

- (iii) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section 3(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE. During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your child is born. This is a “change in status” which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within thirty (30) days after March 15, (that is, by April 14). If you do not elect to enter the Health FSA within thirty (30) days after this “change in status,” you will not have a second opportunity to enter the Health FSA until the first day of the next Plan Year unless you experience a second Election change event.

- (iv) *Automatic Election if Carryover Amount Exists.* If you do not elect to participate in the Health FSA for the Plan Year, but you have a Carryover Amount (defined below) from a prior Plan Year, you will nevertheless be automatically re-enrolled in the Health FSA with a deemed election of zero dollars. The sole purpose of the election of zero dollars is to allow you the opportunity to spend the Carryover Amount. This special rule for Carryover Amounts shall apply unless you have affirmatively elected to forfeit the Carryover Amount on a form provided by either the Plan Administrator or Claims Administrator.

- (f) *Plan Benefits.* If you elect to participate in the Health FSA, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. To determine how much you should reduce your salary for medical reimbursement benefits, you should estimate the amount of medical and dental expenses you expect to have for the Plan Year in which your health or dental insurance will not cover. When you incur uninsured medical or dental expenses, the Plan Administrator will reimburse you for those expenses. The amount of salary you reduce for these medical or dental expenses is not subject to income tax or FICA.

EXAMPLE: You elect to reduce your salary by \$1,200 for the Plan Year. You have \$300 in carryover funds from the prior Plan Year. Therefore, \$1,500 is your maximum reimbursement for uninsured medical expenses incurred for that Plan Year.

If you do not incur uninsured medical expenses for the Plan Year equal to the maximum reimbursement amount plus any amount allowed as a “carryover” from a prior year, you will lose the unused portion up to the maximum Carryover Amount (defined in (g)(i) below).

EXAMPLE: Assume you elect to reduce your salary by \$1,200 for medical expenses and you have a Carryover Amount of \$300 from the prior Plan Year, for a total of \$1,500 in funds. You incur only \$500 of uninsured expenses for the current Plan Year. Although you will be entitled to carry over the maximum Carryover Amount permitted by the Plan to the subsequent Plan Year, you will forfeit the remaining balance, as required by IRS regulations. This example illustrates the importance of carefully estimating your uninsured medical expenses for the Plan Year.

If the Employer determines after the claims run-out period and after processing all pending claims and all Carryover Amounts that the total premiums paid by all Participants in the Health FSA plan exceed the total reimbursements paid out, the Plan will have a surplus. Such surplus will be used to offset reasonable administrative costs. Any surplus remaining after such costs are paid will be used to reduce the required premiums in the following Plan Year. If you are a Participant in the Health FSA on the date of the first payroll following the date on which the amount of surplus has been determined, you will receive a reduction in the cost of your premium, known as a “premium holiday.”

If the Health FSA is terminated by the Employer before or at the end of the Plan Year, then the Employer will determine whether or not there is a surplus. There is a surplus if the total contributions from all Participants exceed the total Health FSA reimbursements. This determination will not be made until after the claims run-out period and after all pending claims have been processed. The Employer will use the surplus, if any, to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed to all individuals who were participating in the Health FSA on the date of the Plan’s termination. The amount of remaining surplus will be divided by the number of Participants entitled to the distribution in order to determine each person’s share. In no case will the surplus be allocated to you based directly or indirectly on your claims experience or on the amount of your annual election.

- (g) *Maximum Benefit Amount.* Under the Health FSA, if you or your dependents incur a “qualified medical expense” for which you submit a timely claim for reimbursement, you will receive a reimbursement for the portion of that expense that is not covered by medical or dental insurance; however, your reimbursements may not exceed the maximum reimbursement amount.
- (i) *Maximum Reimbursement Amount – General Rule.* The maximum reimbursement amount for a Plan Year, plus the amount, if any, of the contributions made by the Employer to the Participant’s Health FSA for that Plan Year, may not exceed the total amount that you have elected to contribute to the Health FSA for that Plan Year.
- (ii) *Limits on Contributions to a Health FSA.* The amount that you elect to contribute to the Health FSA for a Plan Year may not exceed the maximum dollar limit that is established each year by the Employer nor may it be lesser than the minimum dollar limit, if any, established each year by the Employer. The maximum dollar limit, in turn, may not exceed the statutory dollar limit established in the Code, as adjusted by the IRS for periodic cost-of-living increases. The dollar limit(s) established by the Employer will be communicated in the enrollment materials for the Health FSA. The Plan Administrator will also provide information about this dollar limit upon request.
- (iii) *Maximum Reimbursement Amount – Run-Out Periods.* A claim that is incurred during the previous Plan Year and which is submitted for reimbursement during the Plan’s Run-Out Period will count against the maximum reimbursement amount for the previous Plan Year and not the Plan Year during which reimbursement is made.
- (iv) *Special Carryover Rule.* The maximum reimbursement amount for the current Plan Year, as described above, may be increased by any Carryover Amount you might have. A Carryover Amount is the amount, if any, remaining in your Health FSA account from the previous Plan Year as determined on the last day of the Run-Out Period for that Plan Year. A Carryover Amount is limited to *the lesser of* the maximum dollar amount set by the Employer *or* the maximum IRS dollar limit for carryovers, which may be adjusted annually to reflect changes in the cost of living. Any amount remaining in excess of the Carryover Amount must be forfeited in accordance with IRS rules.
- (v) *Order of Reimbursement.* Reimbursements during the Run-Out Period for current-year claims will be made from current-year amounts in order to maximize the potential Carryover Amount, unless you specifically request otherwise and the Plan Administrator permits such alternative reimbursement ordering.
- (h) *Qualified Medical Expenses.* The “qualified medical expenses” for which you (or your Spouse or “dependent,” as defined in Section 105(b) of the Internal Revenue Code (except that non-disabled dependent children are only covered through the end of the month in which they turn age 26), are entitled to reimbursement under the Health FSA are generally those medical expenses that are tax deductible under Section 213(d) of the Internal Revenue Code and for which you have not otherwise been reimbursed through insurance or any other

means. It also includes menstrual care products as defined in Code § 223(d)(2)(D). Typical expenses include, but are not limited to:

- (i) Deductibles and copayment amounts you pay under your medical or dental or vision care coverage;
- (ii) Medical, dental and/or vision care expenses that have not otherwise been reimbursed;
- (iii) Certain over-the-counter drugs permitted by Code § 213(d); and
- (iv) Certain menstrual care products, such as tampons and pads.

The Health FSA does not reimburse for amounts paid to obtain other health insurance coverage. The Health FSA will only reimburse you for qualified medical expenses incurred while you are a Participant in the Health FSA. Under Internal Revenue Service rules, a qualified medical expense is generally considered to be “incurred” when the treatment is provided and not when you are billed for the treatment or when the treatment is paid for.

Typical expenses not eligible for reimbursement by the Health FSA include, but are not limited to:

- (i) Those reimbursed through any other policy or plan, including Medicare or other Federal programs;
 - (ii) Those incurred before you enroll in the Health FSA;
 - (iii) Those incurred in any year other than the year for which Health FSA contributions are made;
 - (iv) Those claimed as a deduction or credit for Federal income tax purposes; and
 - (v) Those the IRS would not allow as deductions for Federal income tax purposes, except for certain over-the-counter drugs.
- (i) *Run-Out Period.* “Run-out period” means the period that begins at the close of the Plan Year and ends on the March 31st immediately following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the “run-out period.”
 - (j) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Medical Expenses. The electronic payment card may only be used at merchants and service providers which are authorized by the Employer.
 - (k) *How to Submit a Claim.*
 - (i) *Claims Forms.* Except as provided in (ii) below, in the event you have a claim for benefits under the Health FSA, you must submit a claim using the claims form that will be provided to you by the Plan Administrator and following the instructions on that form. The Claims Administrator may require you to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:

- (A) The amount, date incurred and nature of each expense;
 - (B) The name of the person, organization or entity with whom the expense was incurred;
 - (C) The name of the person for whom the expense was incurred;
 - (D) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and
 - (E) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.
- (ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your Health FSA through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this Health FSA Plan; other payments may require further substantiation by you to the Health FSA Plan. Please note that, if you present your electronic payment card as payment for a medical expense and it is denied at the point-of-sale (i.e., when the service or item is provided), that denial of payment will *not* constitute an initial claim denial under these procedures.
- (l) *Claims Administrator.* Surency Life & Health will act as Claims Administrator with respect to any claim for benefits under this Health FSA Plan. Surency Life & Health is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.
- (m) *Recoupment of Underwithheld Amounts.* In the event that not enough salary is withheld from your paycheck, resulting in insufficient funds in your Health FSA, the Employer will seek recoupment of the amount of the insufficient withholding.
- (n) *Minimum Claim Amount.* Any claim submitted must total at least \$25 unless (i) the balance remaining in your account is less than \$25, or (ii) the claim is submitted after you terminate your participation in the Health FSA or after the end of the Plan Year.
- (o) *Timing of Claims.* Subject to the Special Carryover Rule, you may make your claim for benefits for expenses incurred during any Plan Year against your account for that Plan Year. You may submit your claim for benefits under the Health FSA Plan during the Plan Year in which incurred or within the “run-out period” following the close of the Plan Year. If you terminate your participation in the Health FSA or if the Employer terminates the Health FSA Plan, you must submit your claim for reimbursement for that Plan Year no later than thirty (30) days after the date of your termination or the date the Employer terminates the Health FSA Plan, respectively. For example, if you terminate

employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than August 30 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.

- (p) *Time Frame for Deciding Claims.* If any claim for benefits under this Health FSA is denied, in whole or in part, then the Claim Administrator will promptly furnish you, within thirty (30) days of receipt of the claim, written notice:
 - (i) Setting forth the reason for the denial;
 - (ii) Making reference to pertinent Health FSA provisions upon which the denial is based;
 - (iii) Describing any additional material or information which is necessary and why;
 - (iv) Referencing any internal rule, guideline, or protocol, or similar criterion relied upon in making the adverse determination (if applicable); and
 - (v) Explaining the claim review procedure set forth herein, including applicable time limits and a statement of your right to bring a civil action under ERISA § 502(a) following an adverse determination upon review.
- (q) *Extension of Time Frame for Deciding Claims.* The Claim Administrator may seek one extension of up to fifteen (15) days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan. You will be notified of the extension prior to the expiration of the initial thirty (30) day period. If the extension is due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and give you at least forty-five (45) days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which you responds to the request for information.
- (r) *Appealing a Claim Denial.* If your claim is denied, in whole or in part, you have one hundred eighty (180) days to submit an appeal. You may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.
- (s) *Time Frame for Deciding Appeal.* The Plan Administrator shall render a decision on review no later than sixty (60) days after receipt of your request for review.
- (t) *Decision on Appeal.* In conducting the review, no deference will be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the claim (or the person's subordinate), will make the determination upon appeal. The decision on review shall be in writing. If the claim is once again denied, in whole or in part, then the notification shall (i) state the reason for the decision, (ii) refer to the Health FSA provisions upon which it is based, (iii) state your right to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, (iv) describe any voluntary appeals procedures, and (v) state your right to bring an action under ERISA § 502(a).

- (u) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services. Prior to making any payment of benefits under the Health FSA, Surency Life & Health (or the Plan Administrator) may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. Surency Life & Health and/or the Plan Administrator may rely upon all such information furnished to it, including your current mailing address. Furthermore, Surency Life & Health (or the Plan Administrator), prior to making payments under the Plan, may require you to file all appropriate claims and requests for payment from any other plan or plans maintained by the Employer, including requests for payment with any insurance carrier which has the responsibility for making any benefit payments under any plans maintained by the Employer.
- (v) *Termination of Coverage.* Your participation in the Health FSA ends on whichever of the following dates occurs first:
 - (i) The last day of the pay period in which you cease to be an Eligible Employee;
 - (ii) The date in which your election to participate expires;
 - (iii) The end of a period in which you last paid a required contribution; or
 - (iv) The date the Employer terminates the Health FSA.

Your coverage for benefits under the Health FSA ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD. You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in your Health FSA as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

- (w) *Qualified Reservist Distributions (QRDs).* A “qualified reservist distribution” is a distribution of all or a portion of your account balance if you are called to active military service, provided the call to service is for a period of one hundred eighty (180) days or more or for an indefinite period of time.
 - (i) *Amount of QRD.* Unless a lesser amount is specifically requested, the QRD will be the total of your contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.
 - (ii) *Timeframe for Requesting a QRD.* You must request a QRD on or after the date you are called to active military service and prior to the end of the Run-Out Period immediately following the end of the Plan Year in which you are called to service.
 - (iii) *Timeframe for Claims Administrator to Respond to a QRD Request.* The Claims Administrator shall respond to any timely request for a QRD within sixty (60) days of the date it receives the request, including providing payment of the

distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth above in this Health FSA section of the SPD, except that the time frame set forth in (o) above is sixty (60) days instead of thirty (30) days.

- (iv) *Eligible Claims.* If you request a QRD, you forfeit the right to receive reimbursements for Qualified Medical Expenses incurred after the date of your last day of active employment. You will be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment or if later, the date of your QRD request, provided that the total dollar amount of such claims does not exceed the amount of your election minus the sum of your QRD and prior reimbursements received for the Plan Year.
- (v) *No Penalty on QRD.* The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in your gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

(8) Dependent Care Assistance Plan

The Employer maintains a DCAP that pays benefits out of the Employer's general assets.

- (a) *Type of Plan.* The DCAP is a Code Section 129 dependent care assistance plan. The DCAP is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan.
- (c) *Election to Participate in the Plan.* To become a Participant in the DCAP, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the DCAP, the Employer will not provide you with any benefits under the DCAP.**
- (d) *Effective Date of Election.* If you elect to participate in the DCAP, your Election will take effect and you will become a Participant as follows:
 - (i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year.
 - (ii) *Election Made by A Newly Eligible Employee.* If you are a newly eligible employee, your Election will take effect when you become a Participant in the Plan.

EXAMPLE. You begin working as a full-time employee on March 15. You complete thirty (30) days of employment with the Employer on April 14. You timely elect to participate in the DCAP. Your Election takes effect on May 1.

- (e) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section 3(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE. During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your Spouse begins a full time job. This is a “change in status” which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within thirty (30) days after March 15, (that is, by April 14). If you do not elect to enter the DCAP within thirty (30) days after this “change in status,” you will not have a second opportunity to enter the DCAP until January 1 of the following year unless you experience a second Election change event.

- (f) *Plan Benefits.* If you elect to participate in the DCAP, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. Under the DCAP, the maximum amount of reimbursement you may receive for a Plan Year is limited to the actual amount of your salary reduction for the Plan Year.
- (g) *Maximum Benefit Amount.* The benefits you receive under this DCAP may not exceed the maximum amount specified in the Internal Revenue Code or be less than the minimum set by the employer. The maximum amount specified in the Internal Revenue Code is \$5,000 (or \$2,500 if you are a married person filing a separate return) *per calendar year* or, if less, your “earned income limitation.” The maximum benefit amount *per plan year* is also \$5,000 (or \$2,500 if you are a married person filing a separate return) or, if less, your “earned income limitation.” The “earned income limitation” is your earned income, if you are not married. If you are married, the earned income limitation is the lesser of your earned income or your Spouse’s earned income.
- (h) *IRS “Use It or Lose It” Requirement.* You should carefully evaluate the amount of your salary reduction for dependent care expenses. ***If your dependent care expenses are less than the amount by which you have reduced your salary for the Plan Year, you will forfeit the excess amount.*** This is an IRS requirement.
- (i) *Election Changes.* Once you make an Election to participate in this DCAP, that Election may not be changed in the middle of the Plan Year, either as to your participation in the Plan or as to the dollar amount you elected, unless an Election change is permitted under the terms of the Plan (see Section 3(d) of this SPD).
- (j) *Federal Income Tax Considerations.* You may be able to claim a Dependent Care Tax Credit on your federal income tax return for your dependent care expenses. The availability of this credit depends on the number of dependents you have and your gross income. More information about the federal Dependent Care Tax Credit may be found in IRS Publication No. 503. ***You may not claim a credit on your federal income tax return for any dependent care expenses for which you have been reimbursed by the DCAP.*** In many cases, you may save more money by receiving tax-free reimbursements under the Plan than by claiming the tax credit. ***Consult your own tax advisor if you are in doubt as to whether to obtain reimbursements under the Plan or to take the tax credit.***

(k) *Qualified Dependent Care Expenses.* A dependent care expense is an amount paid by you for the care of a qualified dependent, including related household services, which enables you to be gainfully employed. The “qualified” dependent care expenses for which you are entitled to reimbursement under the DCAP are generally those dependent care expenses that are permitted under Section 129 of the Internal Revenue Code.

(i) *Qualified Dependent.* A qualified dependent is:

- (A) Your child (as defined in Internal Revenue Code § 152) who is under age 13 and is your “qualifying child” as defined in Code § 152(a)(1); or
- (B) Your tax dependent as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2), and (d)(1)(B), who:
 - (1) Is physically or mentally incapable of caring for himself/herself; and
 - (2) Is living with you for more than one-half of the calendar year.
- (C) Your Spouse who is physically or mentally incapable of self-care and who is living with you for more than one-half of the calendar year.

If you are divorced or separated and have a child whom you do not claim as a dependent for Federal income tax purposes, the child must be in your custody for at least six (6) months out of the year to be a qualified dependent.

(ii) *Types of Expenses Eligible For Reimbursement.* The following expenses are eligible for reimbursement:

- (A) Payments for the care of a qualified dependent in your home. This includes care provided by a babysitter, nurse or housekeeper in your home, as long as part of their service benefits the qualified dependent.
- (B) Payments for the care of a qualified dependent outside your home. If such expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations. If such expenses are incurred for services performed outside your home for an individual described in (k)(i)(B) above, then such individual must be living with you at least eight (8) hours a day.
- (C) Pre-school care, before- and after-school care and day camp during school vacation.

(iii) *Types of Expenses Not Eligible For Reimbursement.* The following expenses are not eligible for reimbursement:

- (A) Expenses paid through another policy or plan providing dependent care benefits to you or your Spouse.

- (B) Amounts paid to your child who is age eighteen (18) or younger for babysitting or care of a qualified dependent.
 - (C) Expenses paid to a person whom you or your Spouse are entitled to claim as a dependent for Federal income tax purposes.
 - (D) Expenses incurred prior to becoming a Participant in the DCAP.
 - (E) Education expenses for a child in kindergarten or any higher grade.
 - (F) Overnight care at a convalescent nursing home for a dependent Spouse or relative.
 - (G) Overnight camp.
 - (H) Expenses for lessons, tutoring or certain types of transportation expenses.
 - (I) Forfeited deposits, but may include application fees, agency fees, and deposits if you are required to pay the expenses to obtain dependent care.
- (l) *Grace Period.* For purposes of the timing of claims for reimbursements under this DCAP, described in Section (o) below, “grace period” means the period that begins immediately following the close of the Plan Year and ends on the March 15th immediately following the end of the Plan Year.
- Eligible expenses *incurred* during the “grace period” may be reimbursed from any funds remaining in your DCAP for the immediately preceding Plan Year.
- (m) *Run-Out Period.* “Run-out period” means the period that begins at the close of the Plan Year and ends on the March 31st immediately following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the “run-out period.”
- (n) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Dependent Care Expenses. The electronic payment card may only be used at service providers which are authorized by the Employer.
- (o) *Claims Procedures.* In the event you have a claim for benefits under the DCAP, you should submit a claim using the claim form that will be provided to you by the Claims Administrator and follow the instructions on that form.
- (i) *Claims Administrator.* The Employer has designated Surency Life & Health to act as the Claims Administrator for the DCAP. As the Claims Administrator, Surency Life & Health shall have the sole authority to grant or deny any claims for benefits under the Plan. If the Claims Administrator denies a claim, it will state its denial in writing and will deliver or mail to the Participant a notice of denial of benefits, setting forth the specific reasons for the denial. In addition, the Claims Administrator will give any Participant whose claim for benefits has been denied a reasonable opportunity for a review of the decision denying the claim.

- (ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your DCAP through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this DCAP Plan; other payments may require further substantiation by you to the DCAP Plan.
- (iii) *Minimum Claim Amount.* Any claim submitted must total at least \$25 unless (A) the balance remaining in your account is less than \$25, or (B) the claim is submitted after you terminate your participation in the DCAP or after the end of the “grace period”.
- (iv) *When to Submit a Claim.* You may submit your claim for reimbursement for expenses you incurred during the Plan Year in which incurred or within the “run-out” period following the close of that Plan Year. However, if you cease participation in the DCAP before the end of the Plan Year, you may continue to incur claims and submit such claims for reimbursement through the end of the “run-out period” following the close of the Plan Year.
 - (A) *Special Grace Period Rule.* You may also make your claim for benefits for expenses incurred during the “grace period” related to that Plan Year against your account for that Plan Year if you are a Participant with DCAP coverage that is in effect on the last day of that Plan Year. Such claims must be made within the “run out period” following the close of the Plan Year.

Claims submitted for reimbursement during the “grace period” (or the “run-out period,” if later) will be first charged against any remaining amount in your DCAP account for the previous Plan Year, unless you specify otherwise on your claims form. All “qualified dependent care expenses” incurred during the Grace Period must be submitted in paper form and not through the use of an electronic payment card, such as a debit card.

Example 1. At the end of Plan Year 1, you have \$400 remaining in your DCAP. You elect to contribute \$5,000 to your DCAP for Plan Year 2. During the “grace period” which follows, you pay your daycare provider \$400 to take care of your child. You immediately turn in your claim for \$400. Your claim will be paid out of the remaining money in your account from Plan Year 1.

Example 2. Continuing with the above example, you find an additional \$50 in receipts for dependent care expenses *incurred* in Plan Year 1. You turn these claims in after the claim for \$400 that you paid to the daycare provider, but before the end of the “run-out period.” This expense is not eligible for reimbursement because it was incurred in Plan Year 1 and you have already depleted your account for Plan Year 1.

- (v) *Claims Decisions and the Right to Appeal.* Within a reasonable time, not exceeding ninety (90) days (unless the Claims Administrator notifies you of an extension of up to ninety (90) days), the Claims Administrator will inform you of its decision to approve or deny your claim. If the Claims Administrator denies your claim, in whole or in part, you may have a right to appeal the decision.
- (vi) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services.
- (vii) *Information Regarding Claims.* Prior to making any payment of benefits under the DCAP, the Claims Administrator may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. The Claims Administrator may rely upon all such information furnished to it, including your current mailing address.
- (p) *Termination of Coverage.* Your participation in the DCAP ends on whichever of the following dates occurs first:
 - (i) The last day of the pay period in which you cease to be an Eligible Employee.
 - (ii) The date in which your election to participate expires;
 - (iii) The end of a period in which you last paid a required contribution;
 - (iv) The date the Employer terminates the DCAP; or
 - (v) You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds the funds in your DCAP as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

(9) Vision Plan

The Employer maintains a Vision Plan that pays benefits under an insurance contract with Surency Life & Health ("Surency"), P.O. Box 789773, Wichita, KS 67278-9773.

- (a) *Type of Plan.* The Vision Plan is a group health plan. The Vision Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Dates.* The eligibility conditions and the Vision Plan entry dates are the same as those for the Plan.

- (c) *Enrollment in the Plan.* **To become a Participant in the Vision Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Vision Plan entry date. **If you do not elect to participate in the Vision Plan, you will not receive any benefits under the Vision Plan.**
- (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Vision Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the Surency group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.
- (d) *Plan Benefits.* If you elect to participate in the Vision Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a group contract between the Employer and Surency. This Vision Plan provides you and/or your dependents with comprehensive vision coverage. Surency has prepared materials which explain the benefits under this Vision Plan in detail. If you have not received these materials from Surency, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Surency is solely obligated to pay for the benefits provided under the Surency group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Vision Plan are determined by Surency and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.
- (g) *Vision Treatment.* The Vision Plan does not provide vision treatment or give vision advice. **It is your responsibility, in consultation with the optometrist of your choice, to get appropriate vision treatment.** The fact that some expense may not be eligible for reimbursement by the Vision Plan does not mean that you or your dependents should not have that treatment.
- (h) *Claims Procedures.* In the event you have a claim for benefits under the Vision Plan, you should follow the procedures outlined in the materials prepared by Surency as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (i) *Termination of Coverage.* Your participation in the Vision Plan ends on whichever of the following dates occurs first:

- (i) The last day of the month in which you terminate your employment with the Employer;
- (ii) The date in which your election to participate expires;
- (iii) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
- (iv) The last day of the month in which you are no longer an Eligible Employee; or
- (v) The day the Employer terminates the Vision Plan.

Your coverage for benefits under the Vision Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(10) Group Life Plan

The Employer maintains a Group Life Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

- (a) *Type of Plan.* The Group Life Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator. The Group Life Plan is an employer paid benefit under the Plan.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the Group Life Plan entry date are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Group Life Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Group Life Plan entry date.
 - (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Group Life Plan.
- (d) *Plan Benefits.* You will be insured under a group contract issued by Guardian. This group contract provides you with life insurance. Guardian has prepared materials which explain the benefits of the group contract in detail. Guardian will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Guardian is solely obligated to pay for the benefits provided under the Guardian group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.

- (f) *Premiums.* The monthly premiums for insurance coverage under the Group Life Plan are determined by Guardian and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will pay 100% of the monthly premium cost.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the Group Life Plan, you should follow the procedures outlined in the materials prepared by Guardian as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (h) *Termination of Coverage.* Your participation in the Group Life Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date on which your election to participate expires;
 - (iii) The last day of the month in which you cease to be an Eligible Employee; or
 - (iv) The date the Employer terminates the Group Life Plan.

Your coverage for benefits under the Group Life Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Guardian. Please refer to the group contract for further details.

(11) Voluntary Life Plan

The Employer maintains a Voluntary Life Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

- (a) *Type of Plan.* The Voluntary Life Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the Voluntary Life Plan entry date are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Voluntary Life Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Voluntary Life Plan entry date. **If you do not elect to participate in the Voluntary Life Plan, you will not receive any benefits under the Voluntary Life Plan.**
 - (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Voluntary Life Plan.

- (d) *Plan Benefits.* If you elect to participate in the Voluntary Life Plan, you will be insured under a group contract issued by Guardian. This group contract provides you and/or your dependents with life insurance. Guardian has prepared materials which explain the benefits of the group contract in detail. Guardian will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Guardian is solely obligated to pay for the benefits provided under the Guardian group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Voluntary Life Plan are determined by Guardian and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on an after-tax basis through the Plan.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the Voluntary Life Plan, you should follow the procedures outlined in the materials prepared by Guardian as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (h) *Termination of Coverage.* Your participation in the Voluntary Life Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date on which your election to participate expires;
 - (iii) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
 - (iv) The last day of the month in which you cease to be an Eligible Employee; or
 - (v) The date the Employer terminates the Voluntary Life Plan.

Your coverage for benefits under the Voluntary Life Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Guardian. Please refer to the group contract for further details.

(12) Short Term Disability Plan

The Employer maintains a Short Term Disability Plan that pays benefits under an insurance contract with The Guardian Life Insurance Company of America ("Guardian"), 7 Hanover Square, New York, NY 10004.

- (a) *Type of Plan.* The Short Term Disability Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the Short Term Disability Plan entry date are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Short Term Disability Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Short Term Disability Plan entry date. **If you do not elect to participate in the Short Term Disability Plan, you will not receive any benefits under the Short Term Disability Plan.**
 - (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Short Term Disability Plan.
- (d) *Plan Benefits.* If you elect to participate in the Short Term Disability Plan, you will be insured under a group contract issued by Guardian. This group contract provides you with short term disability insurance. Guardian has prepared materials which explain the benefits of the group contract in detail. Guardian will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Guardian is solely obligated to pay for the benefits provided under the Guardian group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Short Term Disability Plan are determined by Guardian and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on an after-tax basis through the Plan.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the Short Term Disability Plan, you should follow the procedures outlined in the materials prepared by Guardian as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Guardian has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (h) *Termination of Coverage.* Your participation in the Short Term Disability Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date on which your election to participate expires;

- (iii) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
- (iv) The last day of the month in which you cease to be an Eligible Employee; or
- (v) The date the Employer terminates the Short Term Disability Plan.

Your coverage for benefits under the Short Term Disability Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Guardian. Please refer to the group contract for further details.

(13) AFLAC Pre-Tax Plan

The Employer maintains the AFLAC Pre-Tax Plan that permits Participants to elect to receive benefits under one or more individual policies of insurance issued by American Family Life Assurance of Columbus ("AFLAC"), 1932 Wynnton Road, Columbus, Georgia 31999.

- (a) *Type of Plan.* The AFLAC Pre-Tax Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the AFLAC Pre-Tax Plan entry date are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the AFLAC Pre-Tax Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your AFLAC Pre-Tax Plan entry date. **If you do not elect to participate in the AFLAC Pre-Tax Plan, you will not receive any benefits under the AFLAC Pre-Tax Plan.**
- (d) *Plan Benefits.* If you elect to participate in the AFLAC Pre-Tax Plan, you will be able to select from the following individual policies of insurance which are issued by AFLAC:
 - (i) Critical Illness Plan;
 - (ii) Accident Plan; and/or
 - (iii) Hospital Indemnity Plan.

These individual policies provide you (and your dependents, if family coverage is selected) with various types of insurance. AFLAC has prepared materials which explain the benefits of each individual policy in detail. AFLAC will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.

- (e) *Obligation to Pay Benefits.* AFLAC is solely obligated to pay for the benefits provided under the AFLAC Pre-Tax Plan. The Employer makes no promise and will have no obligation to provide or pay for benefits under the AFLAC Pre-Tax Plan.

- (f) *Premiums.* The monthly premiums for insurance coverage under the various individual policies listed in (d) above are determined by AFLAC and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay 100% of the monthly premium cost. Premiums may be paid on a pre-tax basis through the Plan.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the AFLAC Pre-Tax Plan, you should follow the procedures outlined in the materials prepared by AFLAC as applicable. The Plan Administrator, upon your request, will assist you in making these claims. AFLAC has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (h) *Termination of Coverage.* Your participation in the AFLAC Pre-Tax Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date on which your election to participate expires for the applicable policy or policies;
 - (iii) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
 - (iv) The last day of the month in which you cease to be an Eligible Employee; or
 - (v) The date the Employer terminates the AFLAC Pre-Tax Plan.

Your coverage for benefits under the AFLAC Pre-Tax Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by AFLAC. Please refer to the individual policies for further details.

(14) Legal Services Plan

The Employer maintains a Legal Services Plan that provides benefits under a contract with LegalShield, 1 Pre-Paid Way, P.O. Box 145, Ada, OK 74820.

- (a) *Type of Plan.* The Legal Services Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Legal Services Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Legal Services Plan entry date. **If you do not elect to participate in the Legal Services Plan, you will not receive any benefits under the Legal Services Plan.**

- (d) *Plan Benefits.* You will receive benefits in accordance with the provisions of a group contract issued by LegalShield. LegalShield has prepared materials which explain the benefits of the group contract in detail. LegalShield will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Provide Benefits.* LegalShield is solely obligated to provide the benefits that may be available under the LegalShield group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.
- (f) *Premiums.* The cost of the Legal Services Plan is determined by LegalShield and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on an after-tax basis through the Plan.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the Legal Services Plan, you should follow the procedures outlined in the materials prepared by LegalShield. The Plan Administrator, upon your request, will assist you in making these claims. LegalShield has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract.
- (h) *Termination of Coverage.* Your participation in the Legal Services Plan ends on whichever of the following dates occurs first:
 - (i) The last day of the month in which you terminate your employment with the Employer;
 - (ii) The date on which your election to participate expires;
 - (iii) The last day of the month in which you cease to be an eligible employee; or
 - (iv) The date the Employer terminates the Legal Services Plan.

Your coverage for benefits under the Legal Services Plan ends with the termination of your participation.

(15) 3-in-1 Plan

The Employer maintains a 3-in-1 Plan (includes accident, critical illness, and hospital coverage) that pays benefits under an insurance contract with Reliance Standard Life Insurance Company ("Reliance"), 2001 Market St., Ste. 1500, Philadelphia, PA 19103.

- (a) *Type of Plan.* The 3-in-1 Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

- (b) *Eligibility/Plan Entry Date.* The eligibility conditions and the 3-in-1 Plan entry date are the same as those for the Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the 3-in-1 Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your 3-in-1 Plan entry date. **If you do not elect to participate in the 3-in-1 Plan, you will not receive any benefits under the 3-in-1 Plan.**
 - (i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the 3-in-1 Plan.
- (d) *Plan Benefits.* If you elect to participate in the 3-in-1 Plan, you will be insured under a group contract issued by Reliance. This group contract provides you and/or your dependents with accident, critical illness, and hospital insurance. Reliance has prepared materials which explain the benefits of the group contract in detail. Reliance will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Reliance is solely obligated to pay for the benefits provided under the Reliance group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the 3-in-1 Plan are determined by Reliance and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the 3-in-1 Plan, you should follow the procedures outlined in the materials prepared by Reliance, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Reliance has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.
- (h) *Termination of Coverage.* Your participation in the 3-in-1 Plan ends on whichever of the following dates occurs first:
 - (i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;
 - (ii) The date on which your election to participate expires;

- (iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;
- (iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or
- (v) The day the Employer terminates the 3-in-1 Plan.

Your coverage for benefits under the 3-in-1 Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Reliance. Please refer to the group contract for further details.

(16) COBRA Coverage for Group Health Plans

Special Note: This section only applies if your Employer is required to offer COBRA continuation coverage. Generally, your Employer is required to offer COBRA continuation coverage unless the “small employer” exception to COBRA applies. This exception is based on the number of employees that your Employer employed during the previous calendar year. Generally, if such number is *less than twenty (20)*, then your Employer is *not* subject to COBRA and you should disregard this Section. **In the event, however, that your Employer has twenty (20) or more employees as determined under COBRA**, this Section will apply to an employee covered under a group health plan sponsored by the Employer and to such employee’s covered Spouse and/or covered dependents. **If COBRA applies, you should read this Section carefully.**

COBRA coverage is a temporary extension of coverage under group health plans under certain circumstances when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you and to other members of your family who are covered under the group health plans when group health coverage would otherwise be lost. **This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The group health components of the Plan in which you may be enrolled are the Medical Plan, the Dental Plan, the Vision Plan, and the Health FSA. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires and nothing in this SPD is intended to expand your rights beyond COBRA’s requirements.

- (a) ***Qualified Beneficiary.*** After a qualifying event (described below) occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your Spouse, and your dependent children may become qualified beneficiaries and may be entitled to elect COBRA if coverage under a group health plan is lost because of the qualifying event. (Certain newborns, newly-adopted children, and alternate recipients under NMSNs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

- (b) *Continuation Coverage.* Continuation coverage is the same coverage that the group health plan gives to other Participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the group health plan as other Participants or beneficiaries covered under the plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
- (c) *Qualifying Events.* COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of an event known as a “qualifying event.” Specific qualifying events with respect to each type of qualified beneficiary are as follows:
 - (i) *Employee.* If you are an employee, you will become a qualified beneficiary if you lose (or will lose) your group health coverage under the Plan because either one of the following qualifying events happens:
 - (A) Your hours of employment are reduced; or
 - (B) Your employment ends for any reason other than for gross misconduct.
 - (ii) *Spouse.* If you are the covered Spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:
 - (A) Your Spouse dies;
 - (B) Your Spouse’s hours of employment are reduced;
 - (C) Your Spouse’s employment ends for any reason other than for gross misconduct;
 - (D) Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
 - (E) You become divorced or legally separated from your Spouse. If your Spouse (the employee) reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.
 - (iii) *Dependents.* If you are the covered dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:
 - (A) Your parent-employee dies;

- (B) Your parent-employee's hours of employment are reduced;
- (C) Your parent-employee's employment ends for any reason other than for gross misconduct;
- (D) Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- (E) Your parents become divorced or legally separated; or
- (F) You stop being eligible for coverage under the plan as a "dependent child."

In addition to the above qualifying events, filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

- (d) *FMLA Leave.* If you take FMLA leave and do not return to work at the end of the leave, you (and your Spouse and dependent children, if any) will be entitled to elect COBRA if you, your Spouse and dependent children, if any, (i) were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and (ii) will lose Plan coverage within eighteen (18) months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the group health plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.
- (e) *Special Rule for Health FSAs.* COBRA coverage under a Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if he or she has been reimbursed less money than he or she has contributed.
 - (i) *COBRA Coverage.* COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.
 - (ii) *Qualified Beneficiaries.* Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. Each beneficiary, however, has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary

only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, you should contact the Plan Administrator for more information.

- (f) *COBRA Notice Procedures.* When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within sixty (60) days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with these Notice Procedures. The Plan will not provide you with an Election form to begin or extend COBRA coverage if it does not receive proper notice from you regarding such qualifying events.**

Warning: If your notice is late or if you do not follow these Notice Procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

- (i) *Notices Must Be In Writing And Submitted On Plan Forms.* Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You may obtain copies of required forms from the Plan Administrator). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.
- (ii) *How, When, And Where To Send Notices.* You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided at the beginning of this SPD.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Section of the SPD.)

- (iii) *Information Required For All Notices.* Any notice you provide must include: (A) the name of the Plan; (B) the name and address of the employee who is (or was) covered under the Plan; (C) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (D) the qualifying event and the date it happened; and (E) the certification, signature, name, address, and telephone number of the person providing the notice.

- (iv) *Additional Information Required For Notice of Divorce Or Legal Separation.* If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.
- (v) *Additional Information Required For Notice Of Disability.* Any notice of disability must include: (A) the name and address of the disabled qualified beneficiary; (B) the date that the qualified beneficiary became disabled; (C) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (D) the date that the Social Security Administration made its determination; (E) a copy of the Social Security Administration's determination; and (F) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.
- (vi) *Additional Information Required For Notice Of Second Qualifying Event.* Any notice of a second qualifying event must include: (A) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (B) the second qualifying event and the date that it happened; and (C) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.
- (vii) *Who May Provide Notices.* The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.
- (g) *Electing COBRA Coverage.* Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, the covered employee's Spouse may elect COBRA even if the employee does not. COBRA may be elected for one, several, or for all dependent children who are qualified beneficiaries. Covered employees and Spouses (if the Spouse of a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.
- (h) *Sixty-Day Election Period.* A qualified beneficiary must elect coverage in writing within sixty (60) days of losing coverage under the Plan (or, if later, within sixty (60) days of being provided a COBRA election notice), using the Plan's Election Form and following

the procedures specified on the Election Form. (A copy of the Plan's Election Form may be obtained from the Plan Administrator.) The Election Form must be mailed or hand delivered to the address indicated at the beginning of this SPD and as indicated on the Plan's Election Form. If you mail your election, it must be postmarked no later than the last day of the 60-day election period. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

- (i) *Failure to Return Election Form.* **If you or your covered Spouse or covered dependent children do not elect continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.**
- (ii) *Rejection of COBRA Rights.* If a qualified beneficiary rejects COBRA before the due date, he or she may change his or her mind as long as a completed Election Form is furnished before the due date.
- (iii) *Elections Under More-Than-One Group Health Plan.* Qualified beneficiaries may be enrolled in one or more group health benefits under the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health benefits under of the Plan under which he or she was covered on the day before the qualifying event.
- (i) *Length of COBRA Coverage.* The COBRA coverage periods described below are *maximum* coverage periods for each type of qualified event. COBRA coverage can end before the end of the maximum coverage periods for several reasons outlined in subsection (k) below.
 - (i) *Employee's Termination of Employment.* COBRA continuation coverage may last for up to 18 months for the former employee, the Spouse and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in subsection (j) below.
 - (ii) *Employee's Reduction of Hours.* COBRA continuation coverage may last for up to 18 months for the employee, Spouse and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in subsection (j) below.
 - (iii) *Death of Employee.* COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.
 - (iv) *Employee Entitlement to Medicare.* COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

- (v) *Divorce or Legal Separation.* COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.
 - (vi) *Loss of Dependent Status.* COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.
 - (vii) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA may not be continued beyond the end of the plan year in which the qualifying event occurred.
- (j) *Extension of Maximum Coverage Period (Not applicable to Health FSA).* If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-month period preceding his or her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)
- (i) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.
 - (ii) *Extension Due to a Second Qualifying Event.* An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability, the twenty-nine (29) months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan if the first qualifying event had not occurred.
 - (iii) *Medicare Extension for Spouse and Dependents.* If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum

coverage period for the Spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

These extensions are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within sixty (30) days of entitlement in accordance with the Plan's Notice Procedures found in Section (f) above.

- (iv) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA will not be extended and will only continue until the end of the plan year in which the initial qualifying event occurred.
- (k) *Termination of COBRA Coverage before End of Maximum Period.* Continuation coverage will be terminated before the end of the maximum period if:
 - (i) Any required premium is not paid before the end of the grace period;
 - (ii) After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan;
 - (iii) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);
 - (iv) The employer ceases to provide any group health plan for its employees;
 - (v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or
 - (vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage, for example, if a Participant or beneficiary engages in fraudulent activities against the Plan.
- (l) *Cost of COBRA Coverage.* Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan Participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.
- (m) *First Payment.* All COBRA premiums must be paid by check or money order, unless your COBRA administrator accepts a debit card. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for COBRA coverage within forty-five (45)

days after the date of your election. (This is the date the Election Notice is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the address indicated on the Election notice (unless, as stated above, your COBRA administrator accepts payment via debit card). You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that forty-five (45) days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

EXAMPLE. You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on November 15. Your initial payment equals the premiums for October and November and is due on or before December 30, which is the 45th day after the date of your COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

- (n) *Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the Election Notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

EXAMPLE. You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on October 15. Your initial payment is due on or before November 29th and should equal the premium for October. You will be required to make monthly premiums, starting with the month of November, by the first of each month. This means that the premium for November is due by the first of November.

- (o) *Grace Periods.* Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of thirty (30) days to make each monthly payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment/month, you will lose all rights to COBRA coverage under the Plan.

- (p) *Children Born to or Placed for Adoption.* A child born to, adopted by or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).
- (q) *Alternate Recipients Under NMSNs.* A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified National Medical Support Notice ("NMSN") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.
- (r) *Address Changes.* In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.
- (s) *Questions.* Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, contact the nearest regional or district office the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through this website.)

(17) Special Retiree Coverage for Kansas Municipal Employees

If you have at least ten years of service with the Employer at the time of your retirement, you (and any Spouse and/or dependents who are covered through you at the time of your retirement) may elect to continue coverage in a Group Health Plan (other than a Health FSA) if each of the conditions set forth below are satisfied:

- (a) *Waiver of COBRA.* You waive your right to elect COBRA continuation coverage.
- (b) *Timely Election to Continue Coverage.* You affirmatively elect to continue coverage under a Group Health Plan (other than a Health FSA) no later than 30 days after your retirement from employment with the Employer.

Note: For purposes of this special retiree coverage, the term "retirement" means that you have terminated employment and are receiving a retirement or disability benefit for your service with the Employer.

- (c) *Coverage of Your Spouse and/or Dependents.* If you elect to continue coverage under this special retiree continuation coverage, you may also elect to cover your Spouse and/or dependent(s) who were covered through you under the Group Health Plan (other than a Health FSA) as of your retirement from employment with the Employer. In order for any such individuals to be covered, however, they also must waive their right to elect COBRA continuation coverage. The coverage of such Spouse and/or dependent(s) shall terminate upon the earliest occurrence of the following events:
- (i) Your coverage under the Group Health Plan terminates;
 - (ii) You turn age 65;
 - (iii) You fail to make a required premium payment on a timely basis;
 - (iv) Your Spouse and/or dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or
 - (v) The Employer terminates the Group Health Plan.
- (d) *Payment of Premium.* You must pay the entire cost of coverage for this retiree continuation coverage. Although the exact premiums will be determined by your Employer, the Employer may also require that you pay an administrative fee of up to twenty-five percent of the cost of the coverage.
- (e) *Termination of Continuation Coverage.* Your special retiree continuation coverage will terminate upon the earliest occurrence of the following events:
- (i) You turn age 65;
 - (ii) You become covered, or become eligible to be covered, under another employer's group health plan;
- Note: The reference to "another employer's group health plan" only refers to an employer of the Participant himself/herself.
- (iii) You fail to make a required premium payment on a timely basis; or
 - (iv) The Employer terminates the Group Health Plan.

If you elect coverage pursuant to this Section, you may terminate the coverage at any time, provided, however, such coverage cannot be reinstated once terminated.

(18) USERRA Continuation Rights

If you are absent from employment as a result of military service, you will have the right to elect continuation coverage for a period of up to twenty-four (24) months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

- (a) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than thirty (30) days, you must pay the entire cost of coverage plus an additional 2%.
- (b) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your Employer's group health plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

(19) Miscellaneous

- (a) *National Medical Support Notice.* Participants in a group health plan and their beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing the determination of whether an order is a "national medical support notice" ("NMSN").
- (b) *Family and Medical Leave Act.* If you take an unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain your benefits under a Group Health Plan on the same terms and conditions as though you were still an active Employee.

If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. You will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

- (i) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave (or with pre-tax dollars to the extent you receive compensation from the Employer during your leave).
- (ii) You may pay your share of the premium pursuant to such other arrangement as may be agreed upon between you and the Plan Administrator.

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA. If you fail to remit your premium payments within thirty (30) days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate your coverage retroactive to the date the unpaid premium payment was due.

- (c) *Return of Premium.* If money is returned in any form by an insurance company that provided or is providing benefits under the Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, or rebates resulting from an insufficient “medical loss ratio” (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.
- (d) *Returns of Benefit Payments Made in Error.* The Plan shall have the right to reimbursement from you, your covered dependents, or assignees for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the you, your covered dependents, or assignees were not entitled.

(20) Participant’s Rights Under ERISA

As a Participant in the plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). You have ERISA rights with respect to all benefits provided through the plan except for the Dependent Care Assistance Plan. ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the plan, including insurance contracts and 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under a group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation 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 your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you

and other plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA.

Enforce Your 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 or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a 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, but only after first exhausting the Plan's internal claims procedures (i.e., exhausting your administrative remedies) within the time frame set forth in the Plan document. 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 a Federal court. The court will 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 Your Questions

If you have any questions about your 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 area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue 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.

(21) Notice of Hospital Rights for Newborns and Mothers

HIPAA requires this SPD to include the following explanation of your rights under the Health Insurance Portability and Accountability Act of 1996. Please note that this statement is made to you by the Federal government. Therefore, the Employer and the Plan Administrator are not responsible for the accuracy or completeness of the explanation, and some of the provisions may not apply to the Plan.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(22) Notice of Rights under the Women's Health and Cancer Rights Act of 1998

The Employer is required by federal law to provide the following notice:

If a group medical plan provides medical and surgical benefits for mastectomies, that plan must also provide coverage for the following, if they are agreed upon by a Participant or beneficiary who is receiving benefits in connection with a mastectomy and that person's attending physician:

- (a) Reconstruction of the breast on which the mastectomy has been performed;
- (b) Reconstruction of the other breast to produce a symmetrical appearance; and
- (c) Prostheses and physical complications of mastectomies, including lymph edemas.

This coverage must be the same as for any other benefit under the plan and is subject to the plan's annual deductibles and co-payment requirements.

(23) Right of Employer to Amend or Terminate

The Employer may at any time amend or terminate the Plan, including any of the plans that are summarized in this SPD by a written instrument signed by the Superintendent of the Employer, as provided for in each of the respective plan documents. Any amendment to any plan will be added to the Plan in writing and communicated to Participants.

* * * * *

BENEFIT ELECTION FORMS



Surency AdvantagePlus
USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN
PRE-TAX EMPLOYEE BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT

Instructions

1. Complete this form in order to elect to receive benefits pre-tax and/or open an FSA. (* = Required Fields)
2. Fax completed form to 316.462.3394 OR forward to:
 Surency Life & Health
 PO Box 789773
 Wichita, KS 67278-9773
www.surency.com
3. If you have any questions regarding this form, please call 866.818.8805.

Accountholder Profile Information

* Last Name, First Name, MI (Please Print)	* Employer	* Social Security Number or Employee ID (EID) as appropriate
* Street Address	* City, State, Zip	* Date of Birth (mm/dd/yyyy)
* E-mail Address	* Daytime Phone Number	* Home Phone Number
* Gender ☐ Male ☐ Female	* Marital Status	☐ Married ☐ Single
* Hire Date (mm/dd/yyyy)	*Hours Worked Per Week	*Payroll Frequency ☐ Monthly ☐ Bi-Weekly (24) ☐ Weekly ☐ Semi-Monthly ☐ Bi-Weekly (26) ☐ Other

***Pre-Tax Benefits Election** (Please choose one of the following enrollment options)

- ☐ I want to receive the pre-tax benefits available through the USD 260 – Derby Public Schools Welfare Benefit Plan (“Plan”). By signing below, I authorize USD 260 – Derby Public Schools (“Company”) to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries.

(Please complete the section immediately below)

Medical Premiums		Dental Premiums		Vision Premiums		Critical Illness Premiums	
Hospital Indemnity Premiums		Accident Premiums		3-in-1 Premiums			

- ☐ I understand the benefits offered under the pre-tax benefit election, however, I decline to participate in the above benefits offered under the Plan for this plan year. I understand that, as a result of this decision, I will not receive any of the pre-tax benefits available through the Plan.

(Please sign below and return)

Note: You may be required to complete a separate enrollment form to participate in the above benefits. This pre-tax election form does not entitle you to coverage under these benefits. It only entitles you to receive these benefits on a pre-tax basis if you choose to enroll in coverage under these benefits.

***FSA Election** (Please choose one of the following enrollment options)

- ☐ I am enrolling in an FSA through my employer. By signing below, I authorize the Company to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries.
(Please complete the section immediately below)
- ☐ I understand the benefits offered under the pre-tax spending program (FSA), however, I choose not to enroll in the program for this plan year. I understand that, as a result of this decision, I will not receive any of the pre-tax benefits available through the FSA Plan for this plan year. (Please sign below and return)

Note: Your employer may also make a contribution to your FSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an FSA exceed the maximum annual contribution limitation.

Plan Type	Amount per pay period	# of Payroll Deductions	Annual Election
Health FSA	_____	_____	_____
Limited FSA	_____ x	_____	= _____
Dependent Care FSA	_____ x	_____	= _____

Check with your employer as to the availability of the Surency Advantage Plus products listed

****If there is a discrepancy between the "per pay period" amount and the "annual election" amount, the "per pay period" amount will be used to enter election amounts****

***Surency AdvantagePlus Benefits Card** Check with your employer as to the availability of the Surency AdvantagePlus Benefits Card

Would you like to access your FSA funds using the Benefits Card? ☐ Yes ☐ No

By checking 'Yes', I certify that the benefits card will only be used for eligible medical expenses, as defined in Code §213(d) of the Internal Revenue Code and that I will not seek reimbursement from any other source for the expenses paid for with the benefits card.

Note: To issue separate debit cards to any dependents eighteen (18) years of age or older, please complete and submit the Additional Benefit Card Request Form.

***Reimbursement Method - Choose only one method**

Please select your primary method of reimbursement from your FSA.

- ☐ Direct Deposit - You will need to provide your bank account information in the Direct Deposit Setup section.
- ☐ Check - All reimbursements will be paid by sending you a check. If choosing this option, skip the Direct Deposit Setup section.

Note: Surency will not issue a reimbursement check until the sum of your claims reaches \$25.

Direct Deposit Setup

This section is required if you have chosen Direct Deposit as your FSA Reimbursement Method above.

*Bank Name

*Account Type ☐ Checking ☐ Savings

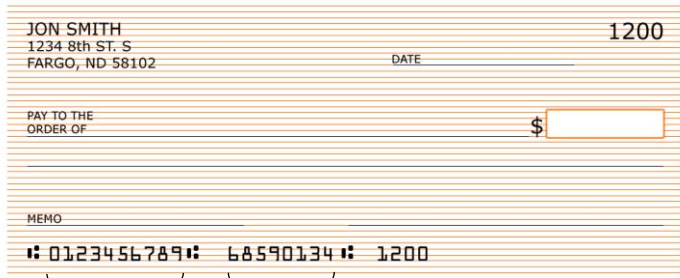
*Bank Address

*City, State, Zip

*Routing Number

*Account Number

**Attach
Voided Check**

* 

Routing Number Account Number

Important Information

- (1) By signing below, you are making a binding election concerning your benefits. You may not change your election until the next enrollment period unless you experience a qualifying "election change event" as defined in the provisions of the Plan.
- (2) A special rule applies to the dollar amounts elected for the Health FSA. If you experience a qualifying "election change event" after the beginning of a plan year, you may begin, increase, decrease or cease your participation in the Health FSA. You may not, however, *decrease* the dollar amount of your election below the total of the amount you have already been reimbursed through the date of the election change event.
- (3) Your election will not remain in effect for subsequent plan years. You must complete a Benefit Election and Salary Reduction Agreement for each plan year. The dollar amounts elected for the Health FSA and Dependent Care Account will automatically be reset to zero for subsequent plan years unless you make a new election for a subsequent plan year.
- (4) The dollar amounts, if any, remaining in your Dependent Care Account at the end of the Plan Year will be forfeited, as required by IRS regulations, if your eligible expenses are not properly submitted for reimbursement before the end of the Run-Out Period. However, if any dollar amount, not exceeding the Plan's "carryover amount" for that year, remains in your Health FSA Account at the end of the Plan Year, the amount may be "carried over" to the subsequent Plan Year. The Plan's "carryover amount" is the maximum carryover amount set by the IRS or, if less, any limit set by the Company. (Please contact the Plan Administrator to find out what the Health FSA "carryover amount" is for the current year.) The "carryover amount" is determined on the last day of the Run-Out Period for the applicable Plan Year. (The Run-Out Period is measured from the last day of the Plan Year.) Any amount remaining in excess of the "carryover amount" shall be forfeited. This is commonly referred to as a "use it or lose it" rule.
- (5) If you have elected above to pay for a benefit provided through AFLAC, this may cause insurance benefit payments received from AFLAC to be subject to federal and state taxes. This will happen if the medical and health benefits you receive from AFLAC exceed the amount of your unreimbursed medical expenses. In other words, to the extent the indemnification amount you receive from AFLAC exceeds the amount you must pay for out-of-pocket medical expenses, you will have "excess indemnification," and the "excess indemnification" is taxable. Accident benefits will generally be tax-free.
- (6) By choosing to receive the benefits available through the Plan, you are authorizing the Company to reduce your salary by the amount necessary to pay your share of the cost for those benefits. By doing this you will reduce your taxable compensation. As a result, depending on your compensation level, you may pay less Social Security tax and this may have some effect on the amount of your Social Security retirement benefits.

The above information is a summary of the provisions of the Plan. In the event of a conflict between this summary and the provisions of the Plan, the provisions of the Plan will control.

By signing below, you agree that the Company can deduct from your wages, to the extent permitted by applicable state law, the amount of any reimbursement paid to you under the Company's Health FSA or Dependent Care Account that is later determined to have been made without proper substantiation or otherwise improperly reimbursed.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

*Employee Effective Date (mm/dd/yyyy)
Complete only if different than plan year effective date.

*Employer Signature

*Date (mm/dd/yyyy)

*Employee Signature

*Date (mm/dd/yyyy)

**USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN
PRE-TAX EMPLOYEE BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT**

Employee Name: _____ Social Security Number: _____

Benefit Election – Select One of the Options Below

_____ I want to receive the pre-tax benefits available through the USD 260 – Derby Public Schools Welfare Benefit Plan (“Plan”). By signing below, I authorize USD 260 – Derby Public Schools (“Company”) to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries:

☐ Medical Coverage

☐ Dental Coverage

☐ Vision Coverage

☐ Critical Illness Coverage

☐ Hospital Indemnity Coverage

☐ Accident Coverage

☐ 3-in-1 Coverage

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

_____ I decline to participate in the above benefits offered under the Plan. I understand that, as a result of this decision, I will not receive any of the above benefits available through the Plan.

Important Information

- (1) By signing below, you are making a binding election concerning your benefits. You may not change your election until the next enrollment period unless you experience a qualifying “election change event” as defined in the provisions of the Plan.
- (2) Your election will not remain in effect for subsequent plan years. You must complete a Benefit Election and Salary Reduction Agreement for each plan year.
- (3) If you have elected above to pay for a benefit provided through AFLAC, this may cause insurance benefit payments received from AFLAC to be subject to federal and state taxes. This will happen if the medical and health benefits you receive from AFLAC exceed the amount of your unreimbursed medical expenses. In other words, to the extent the indemnification amount you receive from AFLAC exceeds the amount you must pay for out-of-pocket medical expenses, you will have “excess indemnification,” and the “excess indemnification” is taxable. Accident benefits will generally be tax-free.
- (4) By choosing to receive the benefits available through the Plan, you are authorizing the Company to reduce your salary by the amount necessary to pay your share of the cost for those benefits. By doing this you will reduce your taxable compensation. As a result, depending on your compensation level, you may pay less Social Security tax and this may have some effect on the amount of your Social Security retirement benefits.

The above information is a summary of the provisions of the Plan. In the event of a conflict between this summary and the provisions of the Plan, the provisions of the Plan will control.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

Signature

Date

**USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN
AFTER-TAX EMPLOYEE BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT**

Employee Name: _____ Social Security Number: _____

Benefit Election – Select One of the Options Below

By signing below, I authorize USD 260 – Derby Public Schools, to deduct from my compensation, on an **after-tax** basis, the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries:

- ☐ Voluntary Life Coverage
- ☐ Short Term Disability Coverage
- ☐ Legal Services Coverage

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

_____ I decline to participate in the above benefits offered under the Plan. I understand that, as a result of this decision, I will not receive any of the above benefits available through the Plan.

Important Information

Your election will not remain in effect for subsequent plan years. You must complete a new salary reduction form for each plan year. Information about each Plan is found in the Summary Plan Description for that Plan. Copies of the Plan documents are available upon request from the Plan Administrator.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

Signature

Date

**USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN
AFTER-TAX EMPLOYEE BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT**

Employee Name: _____ Social Security Number: _____

Benefit Election – Select One of the Options Below

By signing below, I authorize USD 260 – Derby Public Schools, to deduct from my compensation, on an **after-tax** basis, the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries:

☐ Legal Services Coverage

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

_____ I decline to participate in the above benefits offered under the Plan. I understand that, as a result of this decision, I will not receive any of the above benefits available through the Plan.

Important Information

Your election will not remain in effect for subsequent plan years. You must complete a new salary reduction form for each plan year. Information about each Plan is found in the Summary Plan Description for that Plan. Copies of the Plan documents are available upon request from the Plan Administrator.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

Signature

Date

USD 260 – DERBY PUBLIC SCHOOLS WELFARE BENEFIT PLAN
REQUEST TO CHANGE PRE-TAX ELECTIONS

Employee Name: _____

Social Security Number: _____

INSTRUCTIONS. *Please read the following instructions carefully.*

In order to change your election(s) under the USD 260 – Derby Public Schools Welfare Benefit Plan, you must do the following:

- (1) Fill out and return a new Benefit Election and Salary Reduction Agreement
- (2) Tell us why you would like to make a new election or change your current election(s) (using this form)
- (3) Tell us when the event that may allow you to change your election took place (or will take place) (using this form)

After you have provided us with the above information, we will review your request. In determining whether we should accept or deny your request, we must follow IRS rules and the rules set forth in the USD 260 – Derby Public Schools Welfare Benefit Plan. This means, among other requirements, that your request to change your election(s) must be consistent with and on account of the “event(s)” that you have marked below. ***In addition, you must submit your request within 30 days from the date of the event(s) (or 60 days if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP).***

If your request to change your election(s) is approved, it will become effective as follows:

- (1) **HIPAA Special Enrollment for New Dependent.** If your request relates to enrolling a dependent that you have acquired by birth or adoption in the USD 260 – Derby Public Schools Medical Plan, your request will take effect on the date of birth or adoption, even if you submit your request *after* the event (provided you do so within 30 days from the date of the event).

Example. You give birth to a child on March 24th. You submit the appropriate paperwork on April 15th to add your newborn to coverage under the USD 260 – Derby Public Schools Medical Plan. Your new election will be effective retroactively as of March 24th.

- (2) **All Other Changes.** If your request relates to any other type of event, your request will not take effect until the first day of the month coincident with or next following the event, assuming you have completed this form and the Benefit Election and Salary Reduction Agreement. If you timely turn in your forms after the event and after the first business day of the month, your election will not take effect until the first day of the next month.

Example. You are married on January 15th. You submit the appropriate paperwork on January 20th to add your spouse to coverage. The change will take effect February 1. If, on the other hand, you do not submit the completed paperwork until February 5th, your new election will not take effect until March 1st.

REASON YOU WOULD LIKE TO MAKE A CHANGE

HIPAA SPECIAL ENROLLMENT EVENT: *(Applies only to medical benefits)*

If any of the following events occur, you may change your election under the medical benefits in order to add coverage for yourself, your spouse, and/or your dependents. These are known as “HIPAA special enrollment rights.” Please check the appropriate box below if you have experienced a HIPAA special enrollment event and you would like to change your coverage (including changing a coverage option) under the medical benefits:

- ☐ Loss of coverage under another group health plan
- ☐ New spouse through marriage
- ☐ New dependent through birth or adoption
- ☐ Loss of eligibility for Medicaid or a State’s children’s health insurance program (SCHIP)
- ☐ Become eligible for a State premium assistance subsidy from either Medicaid or SCHIP

ALL OTHER EVENTS:

(1) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)

- ☐ Marriage
- ☐ Divorce, legal separation, or annulment (must provide documentation)
- ☐ Death of spouse

(2) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)

- ☐ Birth or adoption of a child (must provide documentation of adoption)
- ☐ Change in "dependent" status (e.g., age, marriage, obtain full-time employment, no longer lives with you)
- ☐ Death of dependent

(3) CHANGE IN EMPLOYMENT STATUS (if it affects benefits eligibility)

	You	Spouse/Dependent
☐ Change from part-time without benefits to part-time with benefits or full-time	_____	_____
☐ Change from full-time or part-time with benefits to part-time without benefits	_____	_____
☐ Beginning of Family and Medical Leave ("FMLA")	_____	N/A
☐ Return from Family and Medical Leave ("FMLA")	_____	N/A
☐ Beginning of an unpaid leave of absence	_____	_____
☐ Returning from unpaid leave of absence.....	_____	_____
☐ Change in worksite.....	_____	_____
☐ Salaried to hourly pay	_____	_____
☐ Hourly to salaried pay	_____	_____
☐ Termination of employment.....	_____	_____
☐ Beginning of employment	_____	_____

Name of dependent: _____

(4) CHANGE FROM 30 OR MORE HOURS PER WEEK TO LESS THAN 30 HOURS PER WEEK (only applies to group health plans other than a health FSA and eligibility for the group health plan is not affected by the reduction in hours worked)

- ☐ Revoke coverage in the following plan(s)*:_____

*In order to make an election change under this option, you (and, if applicable, your Spouse and/or dependents) must enroll in other minimum essential coverage that takes effect no later than the first day of the second month following the month in which you revoke your election under this plan.

(5) CHANGE IN COVERAGE (DOES NOT APPLY TO HEALTH FSA)

- ☐ Addition or significant improvement of a benefit package option
- ☐ Change in coverage under "another employer plan" (Employer, here, means my spouse's or dependent's employer, or, another of my employer's plans, if applicable) and that other plan permits a change for a reason that can be found on this form
- ☐ Open enrollment under "another employer plan" (Employer, here, means my spouse's or dependent's employer, or, another of my employer's plans) and my plan allows me to make an election for a period of coverage that is different from the period of coverage under the other plan
- ☐ Significant reduction in coverage, but coverage is not lost
 - ☐ Significant increase in the deductible
 - ☐ Significant increase in the co-pay
 - ☐ Significant increase in the out-of-pocket cost sharing limit
 - ☐ Other reduction, constituting an overall reduction in coverage (specify):_____

- ☐ Significant reduction in coverage *resulting in a complete loss of coverage*
 - ☐ Elimination of a benefit option
 - ☐ HMO ceasing to be available in the area where I reside
 - ☐ Overall lifetime or annual limitation
 - ☐ Substantial decrease in the medical care providers available under the option
 - ☐ Reduction in the benefits for a specific type of medical condition or treatment with respect to which: ___ I am, ___ my spouse is, ___ a dependent is (Name: _____) currently in a course of treatment.
 - ☐ Other reason that has resulted in a fundamental loss of coverage (specify): _____
- ☐ Loss of coverage under any group health coverage sponsored by a governmental or educational institution, such as one of the following (*please check*): **(DOES NOT APPLY TO DCAP)**
 - ☐ State Children's Health Insurance Program ("CHIP")
 - ☐ A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization
 - ☐ A State health benefits risk pool
 - ☐ A Foreign government group health plan
 - ☐ Other: _____

(6) CHANGE IN COST OF COVERAGE (DOES NOT APPLY TO HEALTH FSA)

- ☐ Significant *increase* in the cost of my benefit package option
- ☐ Significant *decrease* in the cost of my benefit package option

(7) DEPENDENT CARE ASSISTANCE PLAN ("DCAP")

- ☐ Adding a daycare provider or changing daycare providers
- ☐ Change in hours of dependent care
- ☐ Coverage under spouse's or dependent's DCAP decreases or ceases
- ☐ Dependent's enrollment in school has decreased the necessary hours for daycare for (*name*): _____
- ☐ Significant *increase* in the cost of the dependent care provider (except no change can be made where the cost change is imposed by a dependent care provider who is a relative)
- ☐ Significant *decrease* in the cost of the dependent care provider (such that you want to make an election)

(8) OTHER (DOES NOT APPLY TO DCAP ELECTION)

- ☐ Change in residence (*if it affects benefits eligibility*)
- ☐ Issuance of Judgment, Decree, or Order (relating to medical coverage)
- ☐ Entitlement to Medicare or Medicaid is ___ lost ___ gained (*does not apply to non-group health plan benefits*)
- ☐ Enrollment in a "qualified health plan" through the Marketplace due to a special enrollment event or the Marketplace's annual open enrollment period (*does not apply to a health FSA*)

DATE OF EVENT

Please provide the date for each event that you marked above:

Event: _____ Date of Event: _____

Event: _____ Date of Event: _____

By signing below, I understand and agree to the following:

- An election change may be made only if it is permitted under the terms of the Plan and under the terms of Section 125 of the Internal Revenue Code.
- The Plan Administrator may require me to provide appropriate documentation for any event(s) I have marked.
- The Plan Administrator must review and approve any change before it is given effect. The Plan Administrator, in his or her sole discretion, will make election change determinations.
- *I have 30 days from the date of the event to turn in my forms; provided, however, that I have 60 days to turn in my forms if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP (see box on page 1).* If the Plan Administrator determines that I have a valid election change event and the requested change is on account of and consistent with the event, my new election will take effect the first day of the month coincident with or next following the later of the date of the event or the date of the submission of my completed Request to Change Pre-Tax Elections form and Benefit Election and Salary Reduction Agreement. If, however, the event is the birth or adoption of my child, retroactive enrollment in the medical benefit is permitted.

Note: In certain instances, such as the loss of dependent eligibility status, enrollment in certain benefits ends immediately, thereby requiring retroactive termination of coverage. Your dollar election, however, may only be changed prospectively. Thus, if you can anticipate the occurrence of a valid election change event (e.g., the birthday of a dependent, the upcoming hire date of a dependent for a full-time job), then you should submit your completed form and the Benefit Election and Salary Reduction Agreement prior to the date your salary will be reduced to pay for such coverage.

- The statements I have made on this form, including the boxes I have checked, are true and accurate.

(Participant's Signature)

(Date Submitted)

RETURN COMPLETED FORM TO:

**USD 260 – Derby Public Schools
Employee Benefits Department
1550 E. Walnut Grove Road
Derby, Kansas 67037
(316) 788-8526**

For internal use only:

Decision: ☐ Denied ☐ Accepted with respect to _____ benefit for _____.
(Benefit) (Name of Individual)

☐ Denied ☐ Accepted with respect to _____ benefit for _____.
(Benefit) (Name of Individual)

Reason for Denial (if applicable): _____

Accepted and Agreed to: _____
(Plan Administrator's Signature) (Date)

Effective: ____ / ____ / 20__

INITIAL NOTICE OF COBRA RIGHTS

INTRODUCTION

You are receiving this Initial Notice of COBRA Rights (the “Notice”) because you have recently become covered under the **USD 260 – Derby Public Schools Medical Plan, USD 260 – Derby Public Schools Dental Plan, USD 260 – Derby Public Schools Health Flexible Spending Account, and/or USD 260 – Derby Public Schools Vision Plan** (collectively known hereinafter as the “Plan”). This Notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end.

This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This Notice gives only a summary of your COBRA continuation coverage rights. The Plan provides no greater COBRA rights than what COBRA requires – and nothing in this Notice is intended to expand your rights beyond COBRA’s requirements. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description *or* contact the Plan Administrator.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

The name, address, and telephone number of the Plan Administrator are as follows:

**USD 260 – Derby Public Schools
1550 E. Walnut Grove Road
Derby, Kansas 67037
(316) 788-8420**

The Plan Administrator has the responsibility for administering COBRA continuation coverage, but may have contracted with a third-party administrator to carry out the day-to-day COBRA administrative functions on behalf of the Employer. The party responsible for administering day-to-day COBRA administrative functions, or that party’s address and telephone number, may change from time to time. You should consult the Plan Administrator or Summary Plan Description for the most current address if the COBRA administrator changes.

COBRA CONTINUATION COVERAGE

COBRA coverage is a continuation of coverage under the Plan when the coverage would otherwise end because of an event known as a “qualifying event.” Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA coverage must be offered to each person who is a “qualified beneficiary.” You, your covered spouse, and your covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.¹ Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the cost of COBRA coverage.

Employee. If you are an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because either one of the following qualifying events takes place:

- (1) Your hours of employment are reduced so that you are no longer eligible for coverage; or
- (2) Your employment ends for any reason other than your gross misconduct.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because any one of the following qualifying events takes place:

- (1) Your spouse dies;
- (2) Your spouse’s hours of employment are reduced so that you are no longer eligible for coverage;
- (3) Your spouse’s employment ends for any reason other than for gross misconduct;
- (4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.²

Dependent Child. Your dependent children will become qualified beneficiaries *if* they will lose coverage under the Plan because any one of the following qualifying events takes place:

- (1) The parent-employee dies;
- (2) The parent-employee’s hours of employment are reduced so that you are no longer eligible for coverage;
- (3) The parent-employee’s employment ends for any reason other than for gross misconduct;

¹ Certain newborns, newly-adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.

² If your spouse cancels coverage for you in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you lost coverage earlier. You must notify the administrator within 60 days after the divorce or legal separation and establish that your ex-spouse, the employee, canceled the coverage earlier in anticipation of the divorce or legal separation in order for COBRA coverage to be made available for the period after the divorce or legal separation.

- (4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child no longer satisfies the definition of a “dependent child” under the Plan.

Filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all the qualified beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. A qualified beneficiary's COBRA coverage will terminate automatically, however, if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health coverage.

- IMPORTANT -

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the first of the month following the date of the qualifying event.

When the qualifying event is the end of employment, a reduction in hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

For all other qualifying events – that is, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child – *you must notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.*

You must follow the Plan's reasonable procedures for providing notice which are found on the last two pages of this Notice and in your Summary Plan Description. If these procedures are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

MAXIMUM PERIOD OF COVERAGE UNDER THE PLAN

The duration of the maximum period of COBRA coverage will vary depending on (1) the qualifying event and (2) whether or not there is a second qualifying event or a disability extension. The following are COBRA qualifying events if they are coupled with a loss of coverage under the Plan. The maximum period of coverage permitted under COBRA is listed along with each event:

- (1) **Death of the employee** – COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
- (2) **Employee becomes entitled to Medicare (under Part A, Part B, or both) –**
 - (A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
 - (B) See the examples under qualifying events (5) and (6) below for how an employee's entitlement to Medicare may affect the spouse's or dependent child's maximum coverage period when coverage has been lost due to the employee's termination of employment or reduction in hours.
- (3) **Divorce or legal separation –**
 - (A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
 - (B) *Example.* A covered employee and his spouse divorce. If the Plan Administrator is timely and appropriately notified of the divorce, the spouse, who would otherwise lose coverage, may elect COBRA coverage if it is elected within 60 days after the later of the divorce or the loss of coverage in accordance with the Plan's reasonable procedures for providing notice. Any dependent child, who was also covered at the time of the divorce and who will otherwise lose coverage due to the divorce, may also elect COBRA coverage.
- (4) **Dependent child losing eligibility as a dependent child –**
 - (A) COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.
 - (B) *Example.* A dependent child is covered under the Plan. The dependent child turns age 26. As a result, the dependent child will "age-out" of the Plan and lose coverage at the end of the month. Following the Plan's reasonable procedures for providing notice as found in the Summary Plan Description, however, COBRA coverage is timely elected and the individual is given 36 months of continuation coverage.

(5) **Termination of employment –**

- (A) COBRA continuation coverage may last for up to 18 months for the former employee, the spouse and any dependents who are qualified beneficiaries.
- (B) The 18-month period for the spouse and/or dependent child may be extended if there is a “second qualifying event.” See (7) below.
- (C) If the employee became entitled to Medicare benefits less than 18 months before his or her termination of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.
 - (i) *Example.* A covered employee became entitled to Medicare eight (8) months before the date on which his employment terminated. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of his termination (36 months minus 8 months).

(6) **A reduction in the employee’s hours of employment, causing the employee to lose eligibility for coverage –**

- (A) COBRA coverage may last for up to 18 months for the employee, spouse and any dependents who are qualified beneficiaries.
- (B) The 18-month period may be extended if there is a “second qualifying event.” See (7) below.
- (C) If the employee became entitled to Medicare benefits less than 18 months before coverage is lost due to a reduction in hours of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.
 - (i) *Example.* A covered employee became entitled to Medicare eight (8) months before the date on which he stopped being eligible for coverage due to a drop in the number of hours employed. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of the reduction in hours (36 months minus 8 months).

(7) Second Qualifying Event –

- (A) If the employee's family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described below), the spouse and dependent children (along with certain newborns and newly adopted children) can get up to 18 additional months of COBRA coverage, for a maximum of 36 months. In order for this to occur, the following requirements must be met:
 - (i) The spouse and dependent children must be qualified beneficiaries who have elected and paid for COBRA coverage.
 - (ii) COBRA coverage is still in effect for the qualified beneficiaries at the time of the second qualifying event.
 - (iii) The event is one that would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
 - (iv) The Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow its reasonable procedures for providing notice as found in the Summary Plan Description.
- (B) **If the notice procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.**

(8) Disability Extension –

- (A) COBRA coverage may be extended from 18 months to 29 months.
- (B) If the covered employee or anyone in his/her family covered under the Plan is determined by the Social Security Administration to be disabled and the Plan Administrator is notified in a timely fashion, the covered employee and his/her entire family (along with certain newborns and newly adopted children) may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.
- (C) In order to receive the disability extension, each individual must be a qualified beneficiary who has elected and is paying for COBRA coverage and whose COBRA coverage is still in effect at the time of the disability determination.

- (D) The disability must have started some time before the 61st day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage.
- (E) The Plan Administrator must be notified in writing of the Social Security Administration's determination within 60 days after the latest of (a) the date of the determination, (b) the date of the covered employee's termination or reduction of hours, and (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, notice must be given before the end of the 18-month period of COBRA coverage.
- (F) You must follow the Plan's procedures providing notice. **If these procedures are not followed or if notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.**

SPECIAL RULES FOR HEALTH FSA

COBRA coverage under a health flexible spending account ("Health FSA") maintained by the Employer will only be offered to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if he or she has been reimbursed for an amount that is less than his or her contributions through the time of the qualifying event. In addition, the use-it-or-lose-it rule will continue to apply, so any unused amount will be forfeited at the end of the plan year. Finally, COBRA coverage will end on the *last day of the plan year* in which the qualifying event occurred, regardless of the qualifying event.

Each beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

Other Coverage Options In Addition To COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, a qualified beneficiary may have other coverage options during a "special enrollment period" through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

Children Born To Or Placed For Adoption With The Covered Employee During COBRA Period

A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan,

whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (e.g., regarding age).

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Choosing To Enroll in Medicare Instead Of COBRA Continuation Coverage after Group Health Plan Coverage Ends

In general, if the covered employee does not enroll in Medicare Part A or B when first eligible because the covered employee is still employed, then after the Medicare initial enrollment period, the covered employee has an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on *the earlier of*:

- The month after the covered employee's employment ends; or
- The month after group health plan coverage based on current employment ends.

If the covered employee doesn't enroll in Medicare and elects COBRA continuation coverage instead, he/she may have to pay a Part B late enrollment penalty and may have a gap in coverage if he/she decides that he/she wants Part B later. If the covered employee elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate the COBRA continuation coverage. However, if Medicare Part A or B is effective *on or before* the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the covered employee enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If the former covered employee is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the covered employee is not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator's address as indicated on the first page of this Notice.

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any change in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA NOTICE PROCEDURES

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

Notices Must Be In Writing And Submitted On Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You may obtain copies of required forms from the Plan Administrator). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, And Where To Send Notices: You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided on the first page of this Notice.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Notice and in your Summary Plan Description.)

Information Required For All Notices: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required For Notice of Divorce Or Legal Separation: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required For Notice Of Disability: Any notice of disability must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required For Notice Of Second Qualifying Event: Any notice of a second qualifying event must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices: The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

CHECKLIST OF DOCUMENTS TO BE DISTRIBUTED TO PARTICIPANTS UPON BECOMING ELIGIBLE TO PARTICIPATE IN THE PLAN

The following documents should be given to participants at the time they become eligible to participate in the Plan:

1) Summary Plan Description

This is a summary of the main provisions of the Plan. It is recommended that the SPD be distributed to new participants immediately, (and no later than 90 days from the participant's date of entry to distribute the SPD).

2) Pre-Tax Benefit Election and Salary Reduction Agreement

This form is used by the participant to elect in which benefits under the Plan the participant would like to participate and have his or her compensation reduced in order to pay for his or her share of the cost of such benefits on a pre-tax basis. In addition, the form allows the participant to specify how much of his or her salary he or she would like to contribute to the health flexible spending account and/or the dependent care assistance plan. The form also authorizes the company to reduce the participant's compensation and it explains how often the participant can revoke or change the election.

The participant should complete and return this form to the Plan Administrator.

3) After-Tax Benefit Election and Salary Reduction Agreement

This form is used by the participant to elect in which benefits under the Plan the participant would like to participate and have money deducted from his or her compensation in order to pay for such benefits on an after-tax basis. It also authorizes the company to make such deductions and explains how often the participant can revoke or change the election.

The participant should complete and return this form to the Plan Administrator.

4) Initial COBRA Notice

Federal law requires that a notice explaining COBRA rights be given to all covered employees and their spouses participating in group health plans. It is recommended that you send the Initial COBRA Notice via first class mail addressed to the covered employee and the covered employee's spouse (if the spouse is also covered under the Plan). For example, if Jane Smith is your employee, both she and her

husband John Smith are covered under your plan, and they are both living at the same address, an Initial COBRA Notice should be mailed to either "Mr. and Mrs. John Smith" or to "John and Jane Smith." This should be done as soon as possible so that they are aware of their notice obligations to notify the plan administrator if certain events take place, such as a divorce or legal separation. Separate mailings should be made if the employee and spouse live at different addresses. If you give the Notice to an employee at the workplace, you should mail a separate copy to the employee's spouse.

5) HIPAA Privacy Notice

A HIPAA Privacy Notice must be given to the participant if he or she is enrolled the health flexible spending account. This notice informs the participant how his or her "protected health information" may be used or disclosed and it explains his or her individual rights with regard to "protected health information."

6) Other

Any other forms required by the insurance company for an insured plan.