Flexible Benefits Plan
for the Employees of

Ashland School District
DBA Jackson County School District #5

Plan Document
and
Summary Plan Description

Amended Effective: January 1, 2026
Plan Original Effective Date: January 1, 2010

Summary Plan Description

This Plan document also constitutes a Summary Plan Description as required by Internal Revenue Code Section 102.

Flexible Benefits Plan for the Employees of

Ashland School District
DBA Jackson County School District #5

Plan Document and Summary Plan Description

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Section One
Introduction

1.1 Establishment of the Plan

Ashland School District DBA Jackson County School District #5 (the "Employer") hereby establishes the Ashland School District DBA Jackson County School District #5 Flexible Benefits Plan (the "Plan") originally effective January 1, 2010 (the "Effective Date"). This Amended and Restated Plan is effective January 1, 2026 ("Amended and Restated Effective Date").

1.2 Purpose of the Plan

This Plan allows an Employee to participate in the following Benefit Options:

- **Premium Payment Plan ("PPP")** to make pre-tax Salary Reduction Contributions to pay the Employee's share of the premium or Contribution for the Health Plan.
- **Health Flexible Spending Account ("Health FSA")** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Health Care Expenses.
- **Dependent Care Flexible Spending Account ("Dependent Care FSA")** to make pre-tax Salary Reduction Contributions to an account for reimbursement of certain Dependent Care Expenses.

1.3 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under the Internal Revenue Code of 1986, as amended ("Code") Section 125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The **Health FSA** is intended to qualify as self-insured health reimbursement plans under Code Section 105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b).

The **Dependent Care FSA** is intended to qualify as a **Dependent Care Flexible Spending Account** under Code Section 129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a).

Although reprinted within this document, the **Health FSA** and the **Dependent Care FSA** are separate plans for purposes of administration, and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The **Health FSA** is also a separate plan for purposes of applicable provisions of the Consolidated Omnibus Budget Reconciliation Act, as amended ("COBRA"), and the Health Insurance Portability and Accountability Act ("HIPAA").

1.4 Capitalized Terms

Many of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this document or in other relevant sections. When reading the provisions of the Plan, please refer to the Glossary at the end of this document. Becoming familiar with the terms defined there will provide a better understanding of the procedures and Benefits described.

Section Two
General Information

Name of the Plan	Ashland School District DBA Jackson County School District #5 Flexible Benefits Plan
Name of Employer	Ashland School District DBA Jackson County School District #5
Address of Plan	885 Siskiyou Blvd. Ashland, OR 97520 Tel: (541) 482-2811
Plan Administrator	Jackson County School District #5 885 Siskiyou Blvd. Ashland, OR 97520 Tel: (541) 482-2811
Plan Sponsor and its Internal Revenue Service Employer Identification Number	Ashland School District DBA Jackson County School District #5 93-6000507
Named Fiduciary and Agent for Service of Legal Process	Jackson County School District #5 885 Siskiyou Blvd. Ashland, OR 97520 Tel: (541) 482-2811
Type of Administration	The Plan is administered by the Plan Administrator with Benefits provided in accordance with the provisions of the Ashland School District DBA Jackson County School District #5 Flexible Benefits Plan. It is not financed by an insurance company and Benefits are not guaranteed by a contract of insurance. Ashland School District DBA Jackson County School District #5 may hire a third party to perform some of its administrative duties such as claim payments and enrollment.
Plan Number	501
Benefit Option Year	The twelve (12) month period ending December 31.
Plan Effective Date	January 1, 2010
Claims Administrator	HealthEquity Inc. (“HEI”)

Plan Renewal Date	January 1, 2026
Code and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of the Code and other federal regulations. In the event of any conflict between this Plan and the Code or other federal regulations, the provisions of the Code and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and, in its sole discretion, shall determine the appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Plan. 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. Any determination shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any claim for Benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Section Three
Benefit Options and Method of Funding

3.1 Benefits Offered

Each Employee may elect to participate in one or more of the following Benefit Options:

- **Premium Payment Plan ("PPP")** as described in Schedule A.
- **Health Flexible Spending Account ("Health FSA")** as described in Schedule B.
- **Dependent Care Flexible Spending Account ("Dependent Care FSA")** as described in Schedule C.

Benefits under the Plan shall not be provided in the form of deferred Compensation.

3.2 Employer and Participant Contributions

- **Employer Contributions.** The Employer may, but is not required to, contribute to any of the Benefit Options. There are no Employer Contributions for the **PPP** under this Plan; however, if the Participant elects the **PPP** as described in Schedule A, the Employer may contribute toward the Health Plan as provided in the respective plan or policy of the Employer.
- Any nonelective Employer Contributions (e.g., matching Contributions, seed Contributions, or flex credits) to a **Health FSA** does not count toward the maximum dollar limits described in Schedule B. However, if Employer Contributions may be received as cash or as a taxable benefit, then the Employer Contribution will be treated as Salary Reductions if contributed to the **Health FSA** and will count toward the maximum dollar limits described in Schedule B.
- **Participant Contributions.** The Employer shall withhold from a Participant's Compensation by Salary Reduction on a pre-tax basis, or with after-tax deductions, an amount equal to the Contributions required for the Benefits elected by the Participant under the Salary Reduction Agreement. The maximum amount of Salary Reductions shall not exceed the aggregate cost of the Benefits elected.

3.3 Computing Salary Reduction Contributions

- **Salary Reductions per Pay Period.** The Participant's Salary Reduction is an amount equal to:
  - The annual election for such Benefits payable on a regularly occurring basis in the Period of Coverage;

- An amount otherwise agreed upon between the Employer and the Participant; or
- An amount deemed appropriate by the Plan Administrator. (Example: In the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)

- **Salary Reductions Following a Change of Elections.** If the Participant changes his or her election under the **PPP**, **Health FSA**, or **Dependent Care FSA,** as permitted under the Plan, the Salary Reductions will be calculated as follows:
  - An amount equal to:
    - The new annual amount elected pursuant to the Method of Timing and Elections section below;
    - Less the aggregate Contributions, if any, for the period prior to such election change;
    - Payable over the remaining term of the Period of Coverage commencing with the election change;
  - An amount otherwise agreed upon between the Employer and the Participant; or
  - An amount deemed appropriate by the Plan Administrator. (Example: In the event of a shortage of reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate.)

- **Salary Reductions Considered Employer Contributions for Certain Purposes.** Salary Reductions to pay for the Participant's share of the Contributions for Benefit Options elected for purposes of this Plan and the Code are considered Employer Contributions.

- **Salary Reduction Balance Upon Termination of Coverage.** If, as of the date that coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the required Contributions necessary for Benefit Options elected up to the date of termination, the Employer will either return the excess to the Participant as additional taxable wages or recoup the amount due through Salary Reduction amounts from any remaining Compensation.

- **After-Tax Contributions for PPP.** After-tax Contributions for the Benefits elected will be paid outside of this Plan.

3.4 Funding

- **Benefits Paid from General Assets.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer nor the Plan Administrator to maintain any fund or to segregate any amount for the Participant's benefit. Neither the Participant, nor any other person, shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire a third party administrator to perform some of its administrative duties such as enrollment.

- **Notative Account.** While all Benefits are to be paid from the general assets of the Employer, the Employer will keep a notative (i.e., "bookkeeping") account in the name of each Participant. The bookkeeping account is used to track allocation and payment of Benefits.

- **Maximum Contributions.** The maximum Contributions that may be made under this Plan for the Participant are the total of the maximums that may be elected for the **PPP** as described in Schedule A, **Health FSA** as described in Schedule B, and the **Dependent Care FSA** as described in Schedule C.

Section Four
Eligibility and Participation

4.1 Eligibility to Participate

An individual is eligible to participate in this Plan if such individual meets the definition of Employee as set forth in the Glossary.

Eligibility requirements to participate in the individual Benefit Options may vary from the eligibility requirements to participate in this Plan.

4.2 Required Salary Reduction Agreement

To participate in the Plan, an Employee must complete a Salary Reduction Agreement by the methods set forth in Section Five.

The Employee may begin participation on the first of the month coincident with or next following the date on which the Employee has met the Plan's eligibility requirements, or in accordance with the Enrollment requirements each year.

4.3 Termination of Participation

A Participant will terminate participation in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating;
- The termination of this Plan; or
- The end of the month following the date on which the Employee ceases to be an Employee because of retirement, termination of employment, layoff, reduction in hours resulting in loss of eligibility, or any other reason. Where applicable, eligibility may continue beyond such date for purposes of COBRA coverage as set forth in the attached Schedule, and as may be permitted by the Plan Administrator, but not beyond the end of the current Plan Year.

False or Fraudulent Claims. The Plan Administrator has the authority to terminate participation in the Plan if it has been determined that a Participant has filed a false or fraudulent claim for Benefits.

Termination of participation in this Plan will automatically revoke the Participant's participation in the elected Benefit Options, according to the terms thereof. The Benefit Options identified in Schedule A for the **Premium Payment Plan** will terminate as of the date(s) specified in the

applicable insurance plan for each Benefit Option. Any reimbursements from the **Health FSA** and **Dependent Care FSA** accounts after termination of participation will be made pursuant to Schedule B for **Health FSA** Benefits, and Schedule C for **Dependent Care FSA** Benefits.

4.4 Rehired Employees

If a Participant terminates employment with the Employer for any reason, including, but not limited to, disability, retirement, layoff, leave of absence without pay, or voluntary resignation, and then is rehired within the same Plan Year and within thirty (30) days or less of the date of termination of employment, the Employee will be reinstated with the same elections that the Participant had prior to termination as soon as administratively practicable after rehire.

If the Employer rehires a former Participant within the same Plan Year, but more than thirty (30) days following termination of employment and the individual is within the applicable timeframe to be considered an "ongoing employee" for purposes of the Affordable Care Act ("ACA") and the individual is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire.

Notwithstanding the foregoing, the Plan Administrator may limit the **Health FSA** Salary Reduction Contributions of a Participant who is terminated and rehired during the same Plan Year to the extent necessary to comply with the maximum dollar limits described in Schedule B.

4.5 The Family and Medical Leave Act, as Amended ("FMLA") Leaves Of Absence

Health Benefits. Notwithstanding any provision to the contrary, if a Participant goes on a qualifying leave under FMLA, then to the extent required by law, the Participant will be entitled to continue their health coverage Benefits on the same terms and conditions as if the Participant were still an active Employee. For example, the Employer will continue to pay its share of the Contribution to the extent the Participant opts to continue coverage. In the event of unpaid FMLA leave, a Participant may elect to continue such Benefits.

If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contribution:

- With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- With pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, including unused sick days and vacation days; or
- By pre-paying all or a portion of the Contribution for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation.

To pre-pay the Contribution, the Participant must make a special election prior to the date that such Compensation would normally be made available. Pre-tax dollars may not be used to fund coverage during the next Plan Year.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on FMLA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enrollment upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

A Participant whose coverage ceased under any of the aforementioned plans will be entitled to elect whether to be reinstated in such plans at the same coverage level as in effect before the FMLA leave with increased Contributions for the remaining Period of Coverage, or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis will be equal to the amount withheld prior to the period of FMLA leave.

Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as **Dependent Care FSA** Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on leave not qualified as an FMLA leave of absence, as described below. If such policy permits a Participant to discontinue Contributions while on leave then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

4.6 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax Contributions while on leave or with catch-up Contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply. To the extent COBRA applies, the Participant may continue coverage under COBRA.

4.7 Death

Subject to the reimbursement procedures contained herein, a Participant's beneficiaries or representative of the Participant's estate, may submit claims for expenses that the Participant incurred through the end of the month in which the Participant ceases to be eligible for the Plan due to death. A Participant may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Plan Administrator or its designee may designate the Participant's Spouse, another Dependent, or representative of the estate. Claims incurred by the Participant's covered Spouse or any other of the Participant's covered Dependents prior to the end of the month in which the Participant dies may also be submitted for reimbursement.

4.8 COBRA

Under the COBRA rules, as discussed in the attached Schedule B, where applicable, the Participant's Spouse and Dependents may be able to continue to participate under the **Health FSA** through the end of the Period of Coverage in which the Participant dies. The Participant's Spouse and Dependents may be required to continue making Contributions to continue their participation.

4.9 Uniformed Services Employment and Reemployment Rights Act, as Amended ("USERRA")

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue the Benefits that provide health coverage on the same terms and conditions as if the Participant was still an active Employee for up to twenty-four (24) months. In the event of unpaid USERRA leave, a Participant may elect to continue such Benefits during the leave.

If the Participant elects to continue coverage while on USERRA leave, then the Participant may pay his or her share of the Contribution with:

- After-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer; or

- Pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days.

Coverage will terminate if Contributions are not received by the due date established by the Employer. If a Participant's coverage ceases while on USERRA leave for any reason, including for non-payment of Contributions, the Participant will be entitled to re-enrollment in such Benefit upon return from such leave on the date of such resumption of employment and will have the same opportunities to make elections under this Plan as persons returning from non-USERRA leaves. Regardless of anything to the contrary in this Plan, an Employee returning from USERRA leave has no greater right to Benefits for the remainder of the Plan Year than an Employee who has been continuously working during the Plan Year.

Section Five
Method and Timing of Elections

5.1 Automatic Enrollment in Premium Payment Plan ("PPP")

An Employee will commence participation in the **PPP** automatically upon enrolling in the Benefit Plan. The Employee will receive advance notice of the automatic enrollment and may opt out of enrollment in the **PPP** by affirmatively electing to do so no more than thirty (30) days from the date on which the automatic enrollment otherwise occurs. The entire premium portion the Employee pays will be deducted from the Employee's paychecks on a pre-tax basis as described in this Plan.

5.2 Initial Election

Completing a Salary Reduction Election (for **Health FSA** and **Dependent Care FSA** Benefit Options only). An Employee must complete a Salary Reduction Agreement within the election period set forth therein, to enroll in the **Health FSA** and **Dependent Care FSA** Benefit Options. An election is deemed complete only upon the following:

- The Employee completes, signs and returns a Salary Reduction Agreement; or
- If provided by the Employer, the Employee uses the electronic system to make elections. Use of an electronic system will be deemed a completed Salary Reduction Agreement.

Unless otherwise specified by the Employer, an Employee who first becomes eligible to participate in the Plan mid-year will commence participation on the first day of the month coinciding with or after the date the Employee completes a Salary Reduction Agreement for the **Health FSA** and **Dependent Care FSA** Benefit Options.

5.3 Benefit Option Eligibility

Eligibility for Benefits shall be subject to the additional requirements, if any, specified in the applicable Benefit Option. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable Benefit Options.

5.4 Open Enrollment

During each Open Enrollment Period, each Employee who is eligible to participate in the Benefit Plan will have the opportunity to elect to participate in the Benefit Options for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the Benefits elected. The automatic enrollment process described in Section 5.1 will apply to the **PPP** Benefit Option for the next Plan Year unless the Employee elects to opt out as described in Section 5.1.

If an Employee makes an election to participate during an Open Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year.

5.5 Failure to Elect

If an Employee fails to complete a Salary Reduction Agreement within the time described in the Elections paragraphs as discussed immediately above, then the Employee will be deemed to have elected to receive his or her Compensation in cash in lieu of the **Health FSA** or **Dependent Care FSA** Benefit Options. This section does not apply to the **PPP** Benefit Option.

Such Employee may not enroll in the Plan:

- Until the next Open Enrollment Period; or

- Until a qualifying event occurs that would justify a mid-year election change as described in the Irrevocability of Election and Exceptions section below.

Section Six
Irrevocability of Elections and Exceptions

6.1 Irrevocability of Elections

A Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates, except as described in this section.

Guidance. The rules regarding irrevocability of elections and exceptions are complex. The Plan Administrator will interpret these rules in accordance with prevailing IRS guidance. Any factual determinations by the Plan Administrator will be made in its sole discretion, and on a uniform and consistent basis.

6.2 Procedure for Making New Election If Exception to Irrevocability Applies

- **Timing for Making New Election if Exception to Irrevocability Applies**. A Participant may make a new election within sixty (60) days of the occurrence of a qualifying event described in Section 6.4 below, if the election under the new Salary Reduction Agreement is made on account of and corresponds to the event. A Change in Status, as defined below, that automatically results in ineligibility in the Benefit Plan shall automatically result in a corresponding election change, whether or not requested.

- **Effective Date of New Election**. Elections made pursuant to this section shall be effective on the pay period following or coinciding with the Plan Administrator's receipt and approval of the election request for the balance of the Period of Coverage following the change of election, unless a subsequent event allows for a further election change. Except as provided in "Certain Judgments, Decrees and Orders" or for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only.

- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or other document, provided that a Participant may not elect to have **Health FSA** Salary Reduction Contributions in excess of the maximum dollar limits described in Schedule B.

- **Effect on Maximum Benefits.** Any change in an election affecting annual Contributions to the **Health FSA** or **Dependent Care FSA** also will change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated as described in Schedules B and C.

6.3 Change in Status Defined

A Participant may make a new election that corresponds to a gain or loss of eligibility and coverage under this Plan, or under any other plan maintained by the Employer or a plan of the Spouse's or Dependent's employer that was caused by the occurrence of a Change in Status. A Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under prevailing IRS guidance and under this Plan:

- **Legal Marital Status.** A change in a Participant's legal marital status including marriage, death of a Spouse, divorce, legal separation, or annulment;

- **Number of Dependents.** Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption. In the case of the **Dependent Care FSA**, a change in the number of Qualifying Individuals as defined in Code Section 21(b)(1);

- **Employment Status.** Any of the following events that change the employment status of the Participant, Spouse or Dependents:

    - A termination or commencement of employment;

    - A strike or lockout;

    - A commencement of or return from an unpaid leave of absence;

    - A change in worksite; or

    - A change in an individual's status with the consequence that the individual becomes, or ceases to be, eligible under this Plan or another employee benefit plan;

- **Dependent Eligibility Requirements.** An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular Benefit; and

- **Change in Residence.** A change in the place of residence of the Participant, Spouse or Dependent(s).

6.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Benefit.

- **Open Enrollment Period.** A Participant may change an election during the Open Enrollment Period.

- **Termination of Employment**. A Participant's election will terminate upon termination of employment as described in the Eligibility and Participation section above.

- **Leave of Absence**. A Participant may change an election upon a leave of absence as described in the Eligibility and Participation section above.

- **Change in Status** *(applies to the **PPP**, **Health FSA**, as limited below, and **Dependent Care FSA** as limited below).* A Participant may change the actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change corresponds with a gain or loss of eligibility and coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer. This rule is referred to as the general consistency requirement.

  A Change in Status that affects eligibility for coverage also includes a Change in Status that results in an increase or decrease in the number of an Employee's family members who may benefit from the coverage.

  The Plan Administrator, on a uniform and consistent basis, shall determine whether a requested change satisfies the general consistency requirement. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter elections based on the specified Change in Status:

  - **Loss of Spouse or Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health coverage for:

    - The Spouse involved in the divorce, annulment, or legal separation;

    - The deceased Spouse or Dependent; or

    - The Dependent that ceased to satisfy the eligibility requirements.

    Canceling coverage for any other individual under these circumstances fails to correspond with that Change in Status.

Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA or similar health plan continuation coverage under the Employer's Plan, then the Participant may increase his or her election to pay for such coverage. This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** When a Participant, Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of that Participant's Spouse or Dependent, a Participant may elect to terminate or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

- **Special Consistency Rule for Dependent Care FSA Benefits.** With respect to the **Dependent Care FSA**, the Participant may change or terminate the Participant's election upon a Change in Status if:

  - Such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an Employer's Plan; or

  - The election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code Section 129.

- **Reduction of Hours Below Thirty (30) Hours Per Week With or Without Loss of Eligibility** (applies to the **PPP** only). If a Participant who was reasonably expected to average at least thirty (30) hours per week experiences a change in status such that the Participant will reasonably be expected to average less than thirty (30) hours per week, even if the reduction of hours does not result in the Participant's loss of eligibility under the Benefit Plan, the Participant may revoke on a prospective basis a prior election for Health Plan coverage that provides minimum essential coverage (as defined in the regulations governing the employer shared responsibility provisions of the ACA) provided that:

  - The election revocation under the Health Plan corresponds to the Participant's intended enrollment (and the intended enrollment of a Spouse or Dependents whose coverage ceases under the Health Plan due to the revocation) in another plan that provides minimum essential coverage;

- The new plan coverage is effective no later than the first day of the second month following the month that includes the date that the Health Plan coverage is revoked; and

- The Participant provides the Employer with a reasonable representation that the Participant (and the Participant's Spouse and Dependents) has enrolled or intends to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date that the Health Plan coverage is revoked.

- **HIPAA Special Enrollment Rights** (*applies to the **PPP** only*). If the Participant, the Participant's Spouse or Dependent is entitled to HIPAA special enrollment rights under a group health plan, then the Participant may revoke a prior election for group health plan coverage and make a new election provided that the election change corresponds with such HIPAA special enrollment right. As more specifically defined by HIPAA, a special enrollment right will arise in the following circumstances:

  - The Participant, Spouse, or Dependent declined to enroll in group health plan coverage because the Participant, the Participant's Spouse, or Dependent had coverage, and eligibility for such coverage is subsequently lost because the coverage was provided under COBRA and the COBRA coverage was exhausted; or the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the Employer contributions for the coverage were terminated;

  - The Participant acquired a new Dependent as a result of marriage, birth, adoption, or placement for adoption; or

  - The Employee or Dependents who are eligible, but did not enroll for coverage when initially eligible and:

    - The Employee or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within sixty (60) days after the termination; or

    - The Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the Employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

  An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change due to birth,

adoption, or placement for adoption of a new Dependent child may, subject to the group health plan, be effective retroactively back to date of birth, adoption or placement for adoption.

- **Special Enrollment/Annual Enrollment in an Exchange Qualified Health Plan** (applies to the **PPP** only). If a Participant is eligible for a Special Enrollment Period in a Qualified Health Plan ("QHP") through an Exchange pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or if the Employee seeks to enroll in a QHP through an Exchange during the Exchange's open enrollment period, the Participant may revoke a prior election for Benefit Plan coverage that provides minimum essential coverage on a prospective basis provided that:

  - The election revocation under the Benefit Plan corresponds to the Participant's intended enrollment (and the intended enrollment of a Spouse or Dependents whose coverage ceases under the Health Plan due to the revocation) in a QHP through an Exchange;

  - The new QHP coverage through an Exchange is effective no later than the day immediately following the last day of the Benefit Plan coverage; and

  - The Participant provides the Employer with a reasonable representation that the Participant (and the Participant's Spouse and Dependents) has enrolled or intends to enroll in a QHP for new coverage that is effective no later than the day immediately following the last day of the Benefit Plan coverage.

- **Certain Judgments, Decrees and Orders** (a*pplies to the **PPP** and **Health FSA**, but does not apply to the **Dependent Care FSA***). If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order ("QMCSO") requires accident or health coverage, including an election for **Health FSA** Benefits for a Participant's Dependent child, a Participant may:

  - Change an election to provide coverage for the Dependent child provided that the order requires the Participant to provide coverage; or

  - Change an election to revoke coverage for the Dependent child if the order requires that another individual provide coverage under that individual's plan and such coverage is actually provided.

- **Medicare and Medicaid** (*applies to the **PPP** and **Health FSA** as limited below, but does not apply to the **Dependent Care FSA***). If a Participant, Spouse or Dependent is enrolled in a Benefit and becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Benefit Plan covering the person, and the **Health FSA** coverage may be cancelled but not reduced.

However, such cancellation will not be effective to the extent that it would reduce future Contributions to the **Health FSA** to a point where the total Contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Further, if a Participant, Spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the **Health FSA** coverage.

- **Change in Cost** *(applies to the* ***PPP*** *and* ***Dependent Care FSA*** *as limited below, but does not apply to the* ***Health FSA****).* For purposes of this section, "similar coverage" means coverage for the same category of Benefits for the same individuals.

  - **Insignificant Cost Changes.** The Participant is required to increase his or her elective Contributions to reflect insignificant increases in the required Contribution for the Benefit Options, and to decrease the elective Contributions to reflect insignificant decreases in the required Contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances including, but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically make this increase or decrease in affected Participants' elective Contributions on a prospective basis.

  - **Significant Cost Increases**. If the Plan Administrator determines that the cost charged to an Employee for a Benefit significantly increases during a Period of Coverage, the Participant may:

    - Make a corresponding prospective increase to elective Contributions by increasing Salary Reductions;

    - Revoke the election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Option that provides similar coverage; or

    - Terminate coverage going forward if there is no other Benefit Option available that provides similar coverage.

    The Plan Administrator will decide whether a cost increase is significant.

  - **Significant Cost Decreases.** If the Plan Administrator determines that the cost of any Benefit (such as the premium for the Benefit) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes:

- Participants enrolled in that Benefit Option may make a corresponding prospective decrease in their elective Contributions by decreasing Salary Reductions;

- Participants who are enrolled in another Benefit may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; or

- Employees who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator will decide whether a cost decrease is significant.

- **Limitation on Change in Cost Provisions for Dependent Care FSA Benefits.** The above "Change in Cost" provisions apply to **Dependent Care FSA** Benefits only if the cost change is imposed by a Dependent care provider who is not a relative of the Employee.

- **Change in Coverage** (*applies to the **PPP** and **Dependent Care FSA**, but not to the **Health FSA***). The definition of "similar coverage" applied in the Change of Cost provision above also applies here.

  - **Significant Curtailment.** Coverage under a Plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan to constitute reduced coverage generally. If coverage is "significantly curtailed," Participants may elect coverage under a Benefit Option that provides similar coverage. In addition, if the coverage curtailment results in a "Loss of Coverage" as defined below, Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator will decide whether a curtailment is "significant," and whether a Loss of Coverage has occurred in accordance with prevailing IRS guidance.

    - **Significant Curtailment Without Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under a Benefit Option (or the Participant's, Spouse's or Dependent's coverage under the respective employer's plan) is significantly curtailed without a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage and prospectively elect coverage under another Benefit Option, if offered, that provides similar coverage.

    - **Significant Curtailment With a Loss of Coverage.** If the Plan Administrator determines that a Participant's coverage under this Plan (or the Participant's, Spouse's or Dependent's coverage under

the respective employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke an election for the affected coverage, and may either prospectively elect coverage under another Benefit Option that provides similar coverage or drop coverage if no other Benefit Option providing similar coverage is offered by the Employer.

- **Definition of Loss of Coverage.** For purposes of this section, a "Loss of Coverage" means a complete loss of coverage. In addition, the Plan Administrator may treat the following as a Loss of Coverage:

  - A substantial decrease in the health care providers available under the Benefit Plan;

  - A reduction in Benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

  - Any other similar fundamental loss of coverage.

- **Addition or Significant Improvement of a Benefit Option.** If during a Period of Coverage, the Plan adds a new Benefit Option or significantly improves an existing Benefit Option, the Plan Administrator may permit the following election changes:

  - Participants who are enrolled in a Benefit Option other than the newly-added or significantly improved Benefit Option that provides similar coverage may change their election on a prospective basis to cancel the current Benefit Option and instead elect the newly added or significantly improved Benefit Option; and

  - Employees who are otherwise eligible may elect the newly added or significantly improved Benefit Option on a prospective basis, subject to the terms and limitations of the Benefit Option. The Plan Administrator will decide whether there has been an addition of, or a significant improvement in, a Benefit Option.

- **Loss of Coverage Under Another Group Health Coverage.** A Participant may prospectively change an election to add group health coverage for the Participant, Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including, but not limited to, the following:

        - A CHIP under Title XXI of the Social Security Act;

        - A health care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization;

        - A state health benefits risk pool; or

        - A foreign government group health plan, subject to the terms and limitations of the applicable Benefit Option.

    - **Change in Coverage Under Another Employer Plan.** A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan, including a plan of the Employer or a plan of the Spouse's or Dependent's employer, so long as:

        - The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under prevailing IRS guidance; or

        - The Plan permits Participants to make an election for a Period of Coverage that is different from the Plan Year under the other cafeteria plan or qualified benefits plan.

      The Plan Administrator will decide whether a requested change is because of, and corresponds with, a change made under the other employer plan.

    - **Change in Dependent Care Service Provider**. A Participant may make a prospective election change that corresponds with a change in the Dependent care service provider. For example:

        - If the Participant terminates one Dependent care service provider and hires a new Dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and

        - If the Participant terminates a Dependent care service provider because a relative or other person becomes available to take care of the child at no charge, the Participant may cancel coverage.

- **Mistake**. The Plan Administrator will determine whether a Participant has provided clear and convincing evidence that an enrollment Mistake occurred. A Participant may make a prospective election change that corresponds with the Mistake as determined by the Plan Administrator.

A Participant entitled to change an election as described in this section must do so in accordance with the procedures described in this section.

6.5 Election Modifications Required by Plan Administrator

The Plan Administrator may require, at any time, any Participant or class of Participants to amend their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- Satisfy any of the Code's nondiscrimination requirements applicable to this Plan or another cafeteria plan;
- Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of Benefits hereunder than would otherwise be recognized;
- Maintain the qualified status of Benefits received under this Plan; or
- Satisfy any of the Code's nondiscrimination requirements or other limitations applicable to the Employer's qualified Plans.

  In the event that Contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Section Seven
Appeals

7.1 Claims Under the Plan

If a claim for reimbursement under the Plan is wholly or partially denied, or if the Claimant is denied a Benefit under the Plan regarding the Claimant's coverage under the Plan, then the appeals procedure described below will apply.

7.2 Notice from HEI

If a claim is denied in whole or in part, HEI will notify the Claimant in writing within thirty (30) days of the date that HEI received the claim. This time may be extended for an additional fifteen (15) days for matters beyond the control of HEI, including cases where a claim is incomplete. HEI will provide written notice of any extension, including the reason(s) for the extension and the date a decision by HEI is expected to be made. When a claim is incomplete, the extension notice will also specifically describe the required information, and will allow the Claimant at least forty-five (45) days from receipt of the notice to provide the specified information, and will have the effect of suspending the time for a decision on the claim until the specified information is provided. Notification of a denied claim will include:

- The specific reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take to appeal HEI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

7.3 First Level Appeal to HEI

If a claim is denied in whole or in part, the Claimant, or the Claimant's authorized representative, may request a review of the adverse benefits determination upon written application to HEI. The Claimant, or the Claimant's authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and, if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within one hundred eighty (180) days upon receipt of the notice that the claim was denied. If an appeal is not made

within the above referenced timeframe all rights to appeal the adverse benefits determination and to file suit in court will be forfeited.

A written appeal should include:

- Additional documents;
- Written comments; and
- Any other information in support of the appeal.

The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

7.4 HEI Action on Appeal

HEI, within a reasonable time, but no later than sixty (60) days after receipt of the request for review, will decide the appeal. HEI may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents, and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- Appropriate information on the steps to take to appeal HEI's adverse benefits determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, where applicable, with respect to any adverse benefits determination after the final appeal of the claim.

7.5 Voluntary Second Level Appeal

If the decision on review affirms HEI's initial denial, the Claimant may request a voluntary second level review of the adverse appeal determination upon written application to HEI. This

review is a voluntary second level appeal. There are no fees or costs associated with a voluntary second level appeal. A Claimant is not required to initiate a second level appeal before filing a lawsuit; rather a Claimant may bring lawsuit after the denial of the first level appeal.

The Claims Administrator will provide, upon request, sufficient information relating to a voluntary second level appeal to enable a Claimant to make an informed judgment about whether to submit a Benefit dispute to this voluntary second level appeal. A Claimant may request information about the rules applicable to a voluntary second level appeal, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process. A Claimant's decision to submit a Benefit dispute to the voluntary second level appeal will have no effect on the Claimant's rights to any other Benefits under the Plan.

The Claimant, or the Claimant's authorized representative, may request access to all relevant documents in order to evaluate whether to request a voluntary second level appeal of an adverse benefits determination and, if review is requested, to prepare for such review.

A voluntary second level appeal of an adverse appeal determination must be made in writing within sixty (60) days after receipt of the notice that the first level appeal was denied. If a voluntary second level appeal is not made within the above referenced timeframe all rights to appeal the adverse benefit determination will be forfeited. A written appeal should include additional documents, written comments, and any other information in support of the appeal. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies where a Claimant does not elect to pursue a voluntary second level appeal following the first level appeal. Once a Claimant files a voluntary second level appeal, any statute of limitations or any other defense based on timeliness is suspended during the time the voluntary second level appeal is pending. A voluntary second level appeal is closed and no longer pending once the Plan Administrator has decided the appeal.

7.6 HEI Action on Voluntary Second Level Appeal

HEI, within a reasonable time, but no later than sixty (60) days after receipt of the request for review, will decide the appeal. HEI may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial or first level appeal. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

- The specific reason(s) for the appeal decision;
- The specific Plan provision(s) on which the decision is based; and
- A statement regarding the right to review, upon request and at no charge, relevant documents, and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

7.7 Failure to File an Appeal

The Plan's first level appeals procedure must be exhausted before filing a lawsuit or taking other legal action of any kind against the Plan. Failure to follow the Plan's prescribed procedures in a timely manner will result in the loss of your right to file a lawsuit regarding an adverse benefit determination. The denial of the claim shall become final and binding on all persons for all purposes.

7.8 Administrative Exhaustion Requirement

All claim review procedures and the first level appeal provided for in the Plan must be exhausted before any legal action is brought including a claim for Benefits or for breach of fiduciary duty. The voluntary second level appeal does not have to be exhausted prior to bringing any legal action. The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies where a Claimant does not elect to pursue a voluntary second level appeal following the first level appeal.

7.9 Limitation on Actions

Any legal action for the recovery of any Benefits or breach of fiduciary duty must be commenced within **one (1) year** after the Plan's claim review procedures have been exhausted.

7.10 Administrative Record

In any action for the recovery of Benefits, the evidence which may be submitted for review shall be limited to the administrative record on the claim or appeal. Participants may not submit new arguments or theories of recovery in litigation.

Section Eight
Plan Administration

8.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with the terms of the Plan document and for the exclusive benefit of persons entitled to participate in this Plan and without discrimination among them.

8.2 Powers of the Plan Administrator

The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions hereunder. The Plan Administrator shall have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters hereunder. The Plan Administrator shall have the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;

- To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

- To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

- To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

- To furnish each Employee and Participant with such reports in relation to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide Benefits under this Plan;

- To receive, review and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and Benefit consultants;

- To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

- To secure independent medical or other advice and require such evidence as deemed necessary to decide any claim or appeal; and

- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

8.3 Reliance on Participant, Tables, etc.

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

8.4 Outside Assistance

The Plan Administrator may employ such counsel, accountants, administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligations of the Employer and the Plan Administrator.

8.5 Insurance Contracts

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan, and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer Contributions toward such insurance.

8.6 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own gross negligence, misconduct or willful breach of this Plan.

8.7 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

8.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to the Participant or another person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of the Participant or such other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to the Participant or such other person shall be forfeited one (1) year after the date any such payment first became due.

8.9 Effect of Mistake

In the event of Mistake as to the eligibility or participation of an Employee, or the amount of Benefits paid or to be paid to the Participant or another person, the Plan Administrator shall, to the extent administratively possible and otherwise permissible under Code Section 125 or prevailing IRS guidance, correct the Mistake by making the appropriate adjustment to such amounts as necessary to credit the Participant's (or such other person's) account, or withhold any amount due to the Plan / Employer from Compensation paid by the Employer.

8.10 Discrimination Prohibited

In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than twenty-five percent (25%) of all qualified benefits to Key Employees. If, in the judgment of the Plan Administrator, more than twenty-five percent (25%) of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Plan Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Plan Administrator, the Plan shall not be discriminatory. The Plan Administrator shall make such modification of elections by Highly Compensated Participants or Key Employees with or without the consent of such employees.

Section Nine
Amendment or Termination of the Plan

9.1 Permanency

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in the paragraphs below.

9.2 Right to Amend

The Employer reserves the right to merge or consolidate the Plan and to make any amendment or restatement to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Participant.

Any amendment or restatement shall be deemed to be duly executed by the Employer when signed by its Superintendent.

9.3 Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan in whole or in part at any time without prejudice. This Plan may be terminated by the Employer. This Plan also shall terminate automatically if the Employer is legally dissolved, makes a general assignment for the benefit of its creditors, files for liquidation under the Bankruptcy Code, merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan.

Section Ten
General Provisions

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures, if any, to the extent provided in Schedules B and C and then by the Employer.

10.2 No Contract of Employment

Nothing contained in the Plan shall be construed as a contract of employment with the Employer or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee, with or without cause.

10.3 Compliance with Federal Mandates

To the extent applicable for each Benefit Option, the Plan will provide Benefits in accordance with the requirements of all federal mandates, including USERRA, COBRA, HIPAA, Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), Mental Health Parity and Addition Equity Act ("MHPAEA"), Consoidated Appropriations Act of 2021 ("CAA"), and the ACA. In the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.4 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee or Dependent. If the Participant does not supply the requested information within the applicable time limits or provide a release for such information, the Participant will not be entitled to Benefits under the Plan.

10.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its Employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provided herein or as provided by law.

10.6 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the

Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

10.7 Governing Law

This Plan is intended to be construed, and all rights and duties hereunder are governed, in accordance with the laws of the State of Oregon, except to the extent such laws are preempted by Code or other federal law.

10.8 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

10.9 Captions

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

10.10 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the IRS to the extent this Plan Document or any schedule contains advice relating to a federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of avoiding any penalties that may be imposed on the Participant or any other person or entity under the Code or promoting, marketing or recommending to another party any transaction or matter addressed herein.

10.11 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer make any commitment or guarantee that any amounts paid to the Participant or for the Participant's benefit under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the Participant's obligation to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.12 Indemnification of Employer

If the Participant receives one or more payments or reimbursements under this Plan on a pre-tax Salary Reduction basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Section Eleven
HIPAA Privacy and Security

11.1 Provision of Protected Health Information to Employer

For purposes of this section, Protected Health Information ("PHI") shall have the meaning as defined in HIPAA and HITECH. PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased. Electronic Protected Health Information (electronic PHI) means PHI that is transmitted or maintained in electronic media.

Members of the Employer's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the **Health FSA**, plus any other Benefit Option which might be subject to the privacy and security provisions of HIPAA and HITECH (hereinafter referred to collectively as the Plan). When this health information is provided to the Employer, it is PHI, and if it is transmitted by or maintained in electronic media it is electronic PHI. HIPAA, HITECH and the respective implementing regulations restrict the Employer's ability to use and disclose PHI and electronic PHI. The Employer shall have access to PHI and electronic PHI from the Plan only as permitted under this section or as otherwise required or permitted by HIPAA and HITECH.

11.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer information on whether the individual is participating in the Plan.

11.3 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

Summary Health Information means information:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer had provided health benefits under a health plan; and

- From which the required information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

11.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification described below, the Plan may disclose PHI and electronic PHI to the Employer, provided that the Employer uses or discloses such PHI or electronic PHI only for Plan Administration Purposes.

Plan Administration Purposes means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI or electronic PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

11.5 Conditions of Disclosure for Plan Administration Purposes

Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it, the Employer shall:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose PHI for employment-related actions or decisions in connection with the employee benefit plan of Ashland School District DBA Jackson County School District #5;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance with HIPAA's privacy and security requirements;

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

- Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR Section 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and the Employer (i.e., the firewall), required by 45 CFR Section 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

- Ensure that any agents, including subcontractors, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic PHI or to interfere with systems operations in an information system containing electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI .

11.6 Separation Between Plan and Employer

The Employer shall designate such Employee(s) of the Employer who need access to PHI in order to perform Plan administrative functions such as quality assurance, auditing, monitoring, and payroll. No other persons shall have access to PHI. Such specified Employee(s), or classes of Employees, shall only have access to and use of PHI to the extent necessary to perform the Plan administration.

In the event any designated Employee(s) do not comply with the provisions of this section, such Employee(s) shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer’s disciplinary procedures.

The Employer will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent the designees have access to electronic PHI.

11.7 Certification of Plan Sponsor

The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 11.5.

11.8 Organized Health Care Arrangement

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Option and Benefit Plan under 45 CFR Section 160.103 provided by Employer.

Section Twelve
Statement of Rights

12.1 Receive Information About the Plan and Benefits

The Participant may examine without charge at Employer's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report, if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

The Participant may obtain, upon written request to Human Resources, copies of documents governing the operation of the Plan, including insurance contracts and updated Plan Document and Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

12.2 COBRA

The Participant may continue health care coverage for the Participant, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant, Spouse, or Dependents may have to pay for such coverage.

12.3 Prudent Actions by Plan Fiduciaries

The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participant and other Plan participants and beneficiaries. No one, including the Employer or any other person, may fire the Participant or otherwise discriminate against the Participant in any way to prevent the Participant from obtaining a Benefit.

12.4 Enforce the Participant's Rights

If the Participant's claim is denied or ignored, in whole or in part, the Participant has the 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.

If the Participant has a claim for Benefits, which is denied or ignored in whole or in part, and if the Participant has exhausted the claims procedures available to Participant under the Plan, the Participant may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting Participant's rights, Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant has sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if the court finds the claim is frivolous.

12.5 Assistance with Questions

If the Participant has any questions about the Plan, the Participant should contact the Employer's Human Resource Department. If the Participant has any questions about this statement, or if the Participant needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor or contact 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.

In Witness Whereof, Ashland School District DBA Jackson County School District #5 has caused this Plan to be executed in its name and on its behalf, to be effective January 1, 2026.

Ashland School District
DBA Jackson County School District #5

By: ____

Its: ____

Attest: _____________________________________

Its: _____________________________________

Glossary

Capitalized terms used in the Plan have the following meanings:

ACA means the Affordable Care Act.

Benefit(s) means a benefit that is offered as an option for coverage under the corresponding employee health and welfare benefit plan.

Benefit Plan means the underlying employee health and welfare benefit plan.

Cafeteria Plan means the Ashland School District DBA Jackson County School District #5 Flexible Benefits Plan as set forth herein and as amended from time to time.

Claimant means a Participant, a person designated by a Participant who is entitled to a benefit under the Plan, or an authorized representative of a Participant who submits a claim for Plan Benefits in accordance with the Plan procedures for filing Benefit claims as outlined in Section Seven and the schedules attached hereto.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to: (1) any Salary Reduction election under this Plan; (2) any Salary Reduction election under any other cafeteria plan; (3) any compensation reduction under any Code Section 132(f)(4) plan; and (4) any salary deferral elections under any Code Sections 401(k), 408(k) or 457(b) plan or arrangement.

Contribution means the amount contributed to pay for the cost of Benefits as calculated under the Benefit Options.

Dependent, with regard to the **Health FSA** or **PPP**, means the following individuals as more specifically defined in Code Section 152 and the guidance promulgated thereunder**:**

- A person who is a qualifying child or qualifying relative;
- Any child of the Participant who as of the end of the taxable year has not attained age 27; and
- Any child of divorced or separated parents who receives more than half of his or her support from one or both parents and is in the custody of one or both parents for more than half of the calendar year.

Generally, the Code does not allow tax-free health coverage for dependents of a Dependent, or married Dependents filing joint returns. However, under a special rule, such individuals can still

obtain tax-free health coverage, as long as the other Code Section 152 requirements are met. Likewise, a special rule allows tax-free health coverage for individuals who are a "qualifying relative" even if such individuals have gross income in excess of the exemption amount.

In addition, the **Health FSA** Component will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

Dependent, with regard to the **Dependent Care FSA**, means a person who is a qualifying person as defined in Code Section 21, as amended (see also "Qualifying Individual" under the **Dependent Care FSA**).

Dependent Care Expenses has the meaning described in the **Dependent Care FSA** Schedule below.

Dependent Care FSA or Dependent Care Flexible Spending Account means the **Dependent Care Flexible Spending Account** component established by Employer under the Plan. It allows the Participant to use pre-tax dollars to pay for the care of the Participant's eligible Dependents while the Participant is at work.

Earned Income means all income derived from wages, salaries, tips, self-employment, and other Compensation, but only if such amounts are includible in gross income for the taxable year. Earned income does not include: any amounts received pursuant to any **Dependent Care FSA** established under Code Section 129; or any other amounts excluded from earned income under Code Section 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' Compensation.

Effective Date of this Plan shall be January 1, 2026.

Eligible Employee means any Employee who has satisfied the eligibility conditions for the Employer's group medical plan.

Employee means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

The following classes of employees cannot participate in the Ashland School District DBA Jackson County School District #5 Flexible Benefits Plan:

- Leased employees (as defined by Section 414 (n) of the Code);
- Contract workers and independent contractors;
- Temporary employees, casual employees, and employees hired short-term to meet specific needs of the Employer whether or not such persons are on the Employer's W-2 payroll;
- Individuals paid by a temporary or other employment or staffing agency;

- Self-employed individuals; and
- Any more than two percent (2%) shareholders of S corporations.

Employer means Ashland School District DBA Jackson County School District #5.

Exchange means the Health Insurance Marketplace – organized markets where individuals and families can shop for and enroll in health insurance.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Health Care Expenses has the meaning defined in the **Health FSA** Schedule below.

Health FSA or **Health Flexible Spending Account** means the **Health Flexible Spending Account** established by the Employer under the Plan. It allows a Participant to use pre-tax dollars to pay for most health expenses not reimbursed under other programs.

Health Plan means a health benefit plan sponsored by the Employer.

HDHP or High Deductible Health Plan means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Employer.

Highly Compensated Individual means any person who is a "highly compensated individual" as defined in IRC Section 125 and the regulations issued thereunder.

Highly Compensated Participant means any person who is a "highly compensated participant" as defined in IRC Section 125 and the regulations issued thereunder.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH means the Health Information Technology for Economic and Clinical Health Act of 2009.

Key Employee means any person who is a key employee as defined in Code Section 416(i)(1).

Mistake means where there is clear and convincing evidence that a Participant has made an impossible election, or a clerical or administrative error occurred on the part of the Plan Administrator.

Open Enrollment Period with respect to a Plan Year means a period as described by the Plan Administrator preceding the Plan Year during which Participants may make Benefit elections for the Plan Year.

Participant means a person who is an Employee and who is participating in this Plan in accordance with the provisions of the Eligibility and Participation section. Participants include those that elect to receive Benefits under this Plan, and enroll for Salary Reductions to pay for

such Benefits; and those that elect instead to receive their full salary in cash and have not elected the **Health FSA** or **Dependent Care FSA**.

Period of Coverage means the Plan Year, with the following exceptions: (1) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in the Eligibility and Participation section; and (2) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in the Eligibility and Participation section.

Plan means the Ashland School District DBA Jackson County School District #5 Flexible Benefits Plan, as set forth herein and as amended from time to time.

Plan Administrator means Ashland School District DBA Jackson County School District #5.

Plan Year means the twelve (12) month period ending December 31.

PPP means the **Premium Payment Plan.**

Premium Payment Plan means the Benefit Option in which an Employee can elect to participate and have Contributions for the Benefit Plan paid on a pre-tax basis.

PHI means **Protected Health Information** which is information that is created or received by the Plan and relates to the past, present, or future physical, mental health or condition 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; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

QMCSO means a Qualified Medical Child Support Order, as defined in Code Section 609(a).

Qualifying Dependent Care Services has the meaning described in the **Dependent Care FSA** Schedule below.

Qualifying Individual means:

- A tax Dependent of the Participant as defined in Code Section 152 who is under the age of thirteen (13) and who is the Participant's qualifying child as defined in Code Section 152(a)(1);

- A tax Dependent of the Participant as defined in Code Section 152 who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

- A Participant's Spouse, as defined in Code Section 152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code Section 152(e).

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefit Options.

Salary Reduction Agreement means the agreement, whether completed automatically, via form(s), or an internet website, which Employees use to make Benefit elections that spells out the procedures for an Employee to participate in the Plan and elect Salary Reductions to pay for any Benefit Options offered under this Benefit Plan.

Spouse means an individual who is treated as a spouse for federal tax purposes. A common-law spouse shall be eligible for coverage under this Plan if the foregoing requirement is met and the covered Employee submits a written notarized statement affirming the person as his or her Spouse and naming the state of marriage. An individual who is divorced from the covered Employee is specifically excluded from the definition of Spouse. The Plan Administrator may require documentation of an individual's status as a Spouse.

Student means an individual who, during five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly held.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Unused Health FSA Balance means unused **Health FSA** amounts remaining at the end of the Plan Year.

Appendix A
Exclusions—Medical Expenses That Are Not Reimbursable From the Health FSA

The Plan document contains the general rules governing what expenses are reimbursable under the **Health FSA**. This Appendix A, as referenced in the Plan document, specifies certain expenses that are excluded under this Plan with respect to reimbursement from the **Health FSA**—that is, expenses that are *not* reimbursable, even if such expenses meet the definition of "medical care" under Code Section 213(d) and may otherwise be reimbursable under the regulations governing health flexible spending accounts:

- Over-the-counter medications or drugs, unless the medicine or drug meets the requirements outlined in Appendix B.
- Health insurance premiums for any other plan (including a plan sponsored by another employer, a plan offered through the Marketplace, or an individual insurance policy).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.

- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code Section 213(d).
- Any item that is not reimbursable under Code Section 213(d) due to the rules in Prop. Treas. Reg. Section 1.125-5(k)(4) or other applicable law or regulations.

> Refer to Appendix B for rules governing the payment or reimbursement of over-the-counter medicine and drugs.

Appendix B
Over-the-Counter Medicine or Drugs and Debit Cards

This Appendix B applies only to the **Health FSA** only in limited cases where such coverage qualifies as permitted coverage or preventive care.

Over-the-Counter ("OTC") Medicine or Drug Requirements for Reimbursement. Effective December 31, 2019, expenses incurred for medicines or drugs may be paid or reimbursed by your Health FSA.

Items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits, may qualify as medical care if they otherwise meet the definition of medical care in Code Section 213(d)(1). The term medical care includes expenses for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

For purposes of this section, expenses incurred for menstrual care products (as defined in Code Section 223(d)(2)(D)) after December 31, 2019, shall be treated as incurred for medical care for expenses. The term "menstrual care product" means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital tract secretions.

Monthly Limits on Reimbursing OTC Drugs. Only reasonable quantities of OTC medicines or drugs of the same kind may be reimbursed in a single calendar month. Stockpiling is not permitted.

> Note: Prior to the purchase of OTC drugs, Participants should verify with the Claims Administrator that the dispensing drug store, pharmacy or other vendor meets the requirements described below. Failure to do so could result in a **Health FSA** debit card not being accepted and the transaction being deemed unsubstantiated.

Debit Cards. Health FSA debit cards may not be used to purchase OTC medicines or drugs on or after January 1, 2011, except as provided below:

- **Drug Stores and Pharmacies. Health FSA** debit cards may be used to purchase OTC medicines or drugs at drug stores and pharmacies, non-health care merchants that have pharmacies, and mail-order or web-based vendors that sell prescription medicine or drugs if the following requirements are met:
    - The pharmacy or other vendor retains a record of the name of the purchaser or patient, and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for card programs;
    - The records are available to the Employer or its agent upon request;

- The requirements of other IRS guidance regarding card programs are satisfied.

  Health FSA debit cards also may be used to purchase OTC medicines or drugs at a pharmacy that does not have a SIGIS Inventory Information Approval System ("IIAS") if ninety percent (90%) of the store's gross receipts during the prior taxable year consist of items which qualify as expenses for medical care under Section 213(d), provided that substantiation is properly submitted.

- **Other Vendors. Health FSA** debit cards can be used to purchase OTC drugs from vendors with health care-related merchant category codes ("MCCs") if the following requirements are met:

  - The pharmacy or other vendor retains a record of the name of the purchaser or patient and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements for card programs;

  - The records are available to the Employer or its agent upon request; and

  - The requirements of other IRS guidance regarding card programs are satisfied.

Debit card may not be used to purchase OTC drugs at any other providers or merchants after January 15, 2011.

See the following chart for examples of OTC items that are eligible for debit card purchases after December 31, 2019.

Examples of OTC items eligible for debit card purchases:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrhea medicine
- Baby rash ointment
- Bandages
- Braces and supports
- Catheters
- Cold and flu medicine

- Contact lens solution and supplies
- Crutches
- Denture cleaners and adhesives
- Diagnostic tests and monitors (such as blood glucose monitors)
- Elastic bandages and wraps
- Eye drops
- Feminine anti-fungal or anti-itch products
- First-aid supplies
- Hemorrhoid treatment
- Insulin
- Laxatives or stool softeners
- Lice treatments
- Menstrual care products (after December 31, 2019)
- Motion sickness medicines
- Nasal sprays or drops
- Ointments for cuts, burns or rashes
- Ostomy products
- Pain relievers, such as aspirin or ibuprofen
- Reading glasses
- Sleep aids
- Stomach remedies
- Walkers, wheelchairs and canes

Schedule A
Premium Payment Plan

Unless otherwise specified, terms capitalized in this Schedule A shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

A.1 Benefits

Under this **Premium Payment Plan** (“**PPP”**), the Employee may elect the following Benefit Options:

- Health Insurance Premiums
- Dental Insurance
- Vision Care Insurance
- Accidental Death & Dismemberment
- Group Term Life Insurance
- Prescription Drug Coverage Premiums

If the Employee is an enrolled Participant in the Health Plan Benefit Options and timely submits an executed Salary Reduction Agreement, the Employee can either:

- Option A: Elect Benefit Options under the **PPP** by electing to contribute his or her share for the Benefit Options on a pre-tax basis; or
- Option B: Elect no Benefits under the **PPP** and to contribute his or her share, if any, for the Benefit Options with after-tax deductions outside of this Plan.

Benefits elected under Option A will be funded by the Participant’s Contributions as provided in the Eligibility and Participation section.

An Employee will commence participation in the **PPP** automatically upon enrolling in the Health Plan Benefit Options. The Employee will receive advance notice of the automatic enrollment and may opt out of enrollment in the **PPP** by affirmatively electing to do so no more than thirty (30) days from the date on which the automatic enrollment otherwise occurs. The entire premium portion the Employee pays will be deducted from the Employee’s paychecks on a pre-tax basis as described in this Plan.

Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section, such Benefit elections are irrevocable for the duration of the Period of Coverage to which it relates.

A.2 Contributions

The annual Contribution for the **PPP** is equal to the amount as set by the Employer, which may or may not be the same amount charged under the Benefit Plan.

A.3 Benefits Provided Under the Benefit Plan

Benefits will be provided by the Benefit Plan, not this Plan. The types and amounts of Benefits, the requirements for participation, and other terms and conditions of coverage of the Benefit Plan are set forth in the applicable plan document and component benefit documents. No changes can be made under this Plan with respect to the Benefit Plan if such changes are not permitted under the applicable Benefit Plan.

All claims to receive benefits under the Benefit Plan shall be subject to and governed by the terms and conditions of the Benefit Plan and the rules, regulations, policies and procedures adopted in accordance therewith, as may be amended from time to time.

A.4 COBRA

To the extent required by COBRA, the Participant, Spouse and Dependent, as applicable, whose coverage terminates under the Benefit Plan because of a COBRA qualifying event and who is a qualified beneficiary as defined under COBRA, shall be given the opportunity to continue the same coverage that the Participant, Spouse or Dependent had under the Benefit Plan the day before the qualifying event for the periods prescribed by COBRA, on a self-pay basis. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Schedule B
Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule B shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

B.1 Benefit Contributions

The annual Contribution for a Participant's **Health FSA** is equal to the annual Benefit amount elected by the Participant.

B.2 Eligible Health Care Expenses

Under the **Health FSA**, a Participant may receive reimbursement for Health Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred**. With the exception of orthodontia expenses discussed below, a Health Care Expense is incurred at the time the medical care or service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the medical care.

- **Orthodontia Expenses Incurred**. Notwithstanding the foregoing, orthodontia expenses may be reimbursed by this Plan if the expenses have been incurred within the Period of Coverage. This includes orthodontia expenses that are paid in advance of the services being provided if the advance payment is required in order to receive the services (i.e., a down payment is required). Orthodontia expenses will be deemed to have been incurred when the advance payment is made, provided the payment is made within the Period of Coverage.

  Orthodontia expenses may also be reimbursed if a reasonable payment schedule or service contract with expense detail is provided with the claim. A reasonable payment schedule or service contract must be prepared by the Participant's dentist and must illustrate what orthodontia services are to be provided, when the services are planned to be provided (identified by month and year), and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided and subsequent proportional payments in anticipation of follow-up services.

- **Health Care Expenses**. Health Care Expenses means expenses incurred by a Participant, or the Participant's Spouse or Dependent(s) covered under the **Health FSA** for medical care, as defined in Code Section 213(d), other than expenses that are excluded by this Plan, but only to the extent that the Participant or other person incurring the expense is not reimbursed through any other accident or health plan.

- **Expenses That Are Not Reimbursable.** Insurance premiums are not reimbursable from the **Health FSA**. Other expenses that are not reimbursable are listed in Appendix A to the Plan Document.

- **Change in Health FSA Benefits for Children Under Age 27.** As a result of a change to the Code that was part of federal health care reform, a Participant in the **Health FSA** can now be reimbursed for otherwise-eligible Health Care Expenses incurred by a child through December 31 of the calendar year in which the child turns age 26, regardless of the child's residency, employment, financial dependence, Student status, marital status, or status as a tax Dependent. The change applies to expenses that are incurred on or after March 30, 2010, by a child as defined under the Dependent definition in the Glossary section of this document. Otherwise-reimbursable Health Care Expenses incurred by a child before that date will also qualify for reimbursement if the child was the Participant's tax Dependent for health coverage purposes when the expenses were incurred.

- **Change in Medical Insurance Benefits for Children Under Age 27.** As a result of the change to the Code discussed above, if the Participant has a child who is under age 27 as of the end of the calendar year and is currently receiving health coverage, income will not be imputed for the coverage beginning March 30, 2010.

  If you have questions, please contact the Plan Administrator at Ashland School District DBA Jackson County School District #5.

B.3 Maximum and Minimum Benefits

- **Maximum Reimbursement Available; Uniform Coverage Rule.** The maximum dollar amount elected by the Participant for reimbursement of Health Care Expenses incurred during a Period of Coverage, reduced by prior reimbursements during the Period of Coverage, shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's **Health FSA**. Notwithstanding the foregoing, no reimbursements will be available for Health Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided below.

  Payment shall be made to the Participant in cash as reimbursement for Health Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this section have been satisfied.

- **Maximum and Minimum Dollar Limits.** The maximum annual Benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be Three Thousand Four Hundred and No/100 Dollars ($3,400.00) and shall increase each year pursuant to published guidance from the Internal Revenue Service. For any Plan Year, a Participant may not elect **Health FSA** Salary Reduction Contributions in excess of the maximum

dollar limit permitted under health care reform as adjusted for inflation pursuant to Code Section 125(i). The minimum annual Benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Health Care Expenses incurred in any Period of Coverage shall be One Hundred Twenty and No/100 Dollars ($120.00), unless a higher minimum is specified in the Salary Reduction Agreement. Reimbursements due for Health Care Expenses incurred by the Participant's Spouse or Dependent(s) shall be charged against the Participant's **Health FSA**.

- **Changes**. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document, provided that a Participant may not elect to have **Health FSA** Salary Reduction Contributions in excess of the maximum dollar limit permitted under health care reform and described in this Schedule.

- **Mid-Year Proration for New Hires**. If a Participant enters the Plan mid-year, then the maximum annual Benefit the Participant may elect will be prorated on the basis of monthly Contributions. The remaining full months of the Period of Coverage are multiplied by the maximum annual Benefit per month respectively, up to the maximum annual Benefit amount stated above.

- **No Proration for Mid-Year Election Increase**. If a Participant wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may increase coverage, up to the maximum annual benefit amount stated above. The maximum annual Benefit amount will not be prorated.

- **Effect on Maximum Benefits If Election Change Permitted**. Any change in an election affecting annual Contributions to the **Health FSA** will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing on the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:

    - The aggregate Contribution for the period prior to such election change; to

    - The total Contribution for the remainder of such Period of Coverage to the **Health FSA;** reduced by

    - All reimbursements made during the entire Period of Coverage.

- **FMLA Leave.** Any change in an election for FMLA leave will change the maximum reimbursement Benefits in accordance with FMLA or the regulations governing cafeteria plans.

B.4 Establishment of Account

The Plan Administrator will establish and maintain a **Health FSA** with respect to each Participant who has elected to participate in the **Health FSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts**. A Participant's **Health FSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- **Debiting of Accounts**. A Participant's **Health FSA** will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage.

- **Available Amount Not Based on Credited Amount**. The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this section above. It is not based on the amount credited to the **Health FSA** at a particular point in time.

B.5 Use It or Lose It Rule; Forfeiture of Account Balance

- **Use It or Lose It Rule.** Except for any allowable Carryover as set forth below, if any Unused **Health FSA** Balance remains in the Participant's **Health FSA** for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

- **Use of Forfeitures**. All forfeitures under this Plan shall be used as follows:

    - First, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions;

    - Second, to reduce the cost of administering the **Health FSA** during the Plan Year or the subsequent Plan Year; and

    - Third, to provide increased Benefits or Compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with prevailing IRS guidance.

- **Unclaimed Benefits.** Benefit payments that remain unclaimed by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.

Refer to Appendix B for rules governing the payment or reimbursement of OTC medicine and drugs.

B.6 Carryovers

Notwithstanding any other provision of the Plan to the contrary, any Unused **Health FSA** Balance of up to Six Hundred Eighty and No/100 Dollars ($680.00) remaining in a Participant's **Health FSA** Account at the end of a Plan Year can be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year, subject to the following conditions:

- No more than Six Hundred Eighty and No/100 Dollars ($680.00) of the Participant's Unused **Health FSA** Balance for a Plan Year may be carried over for use in the next Plan Year. Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit as defined under Section B.3.

- A Participant who is otherwise eligible for the **Health FSA** for a Plan Year but does not make a **Health FSA** election for that Plan Year may use any Carryovers from the preceding Plan Year for Medical Care Expenses incurred in the current or preceding Plan Year (as further provided herein). However, an Employee or other individual must be a participant in the **Health FSA** as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year. Termination of employment and cessation of eligibility will result in a loss of Carryover eligibility unless a COBRA election is made.

- A Participant may elect prior to the beginning of a Plan Year to waive the Carryover from the preceding Plan Year in accordance with procedures established by the Plan Administrator. A Participant who waives the Carryover may continue to submit claims for Medical Care Expenses incurred during the preceding Plan Year until April 30 of the following Plan Year, to be reimbursed from the Participant's available **Health FSA** amounts.

- Medical Care Expenses incurred during a Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses, cannot exceed Six Hundred Eighty and No/100 Dollars ($680.00), and will count against the Six Hundred Eighty and No/100 Dollars ($680.00) maximum Carryover amount.

- If any Unused **Health FSA** Balance remains for a Plan Year after all reimbursements have been made for that Plan Year in excess of the amount that can be carried over under this subsection, the Participant will forfeit all rights with respect to those amounts, which will be subject to the Plan's provisions regarding forfeitures in Section B.5.

B.7 Reimbursement Procedure

- **Timing**. Within thirty (30) days after receipt of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Care Expenses, or HEI will notify the Participant that a claim has been denied. This time period may be extended for an additional fifteen (15) days for matters beyond the control of HEI, including in cases where a reimbursement claim is incomplete. HEI will provide written notice of any extension, including the reasons for the extension, and will allow the Participant forty-five (45) days from receipt of the written notice in which to complete an incomplete reimbursement claim.

- **Claims Substantiation**. A Participant who has elected to receive Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting a claim to HEI within a runout period of ninety (90) days of the Plan Year, setting forth:

  - The person or persons on whose behalf Health Care Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - The amount of the requested reimbursement;
  - The name of the person, organization, or entity to whom the Expense was or is to be paid;
  - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and
  - Other such details about the expenses that may be requested by HEI in the reimbursement request form or otherwise.

  The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that HEI may request. Except for the final reimbursement claim for a Participant's **Health FSA** for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least Twenty-Five and No/100 Dollars ($25.00). If the **Health FSA** is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to

comply with substantiation procedures established by HEI in accordance with the prevailing IRS guidance.

- **Claims Denied**. For appeal of claims that are denied, see the Appeals Procedure in the Plan Document.
- **Claims Ordering; No Reprocessing.** All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise re-characterized solely for the purpose of paying it from amounts attributable to a different Plan Year or Period of Coverage.

B.8 Reimbursements After Termination; Limited COBRA Continuation

When a Participant ceases to be a Participant under Section 4.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Health Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant, or the Participant's estate, may claim reimbursement for any Health Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim within ninety (90) days after the date that the Participant ceases to be a Participant.

Health FSA expenses are reimbursed up to the full amount of the Participant's annual coverage. If the Participant terminates employment and has been reimbursed for more than the amount the Participant contributed to the **Health FSA**, the Participant does not need to repay the overspent amount.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and such Participant's Spouse and Dependent(s), whose coverage terminates under the **Health FSA** because of a COBRA qualifying event, shall be given the opportunity to continue the same coverage that the Participant had under the **Health FSA** the day before the qualifying event, subject to all conditions and limitations under COBRA. The Contributions for such continuation coverage will be equal to the cost of providing the same coverage to an active Employee taking into account all costs incurred by the Employee and the Employer plus a two percent (2%) administration fee. Specifically, an individual will be eligible for COBRA continuation coverage only if the Participant's remaining available amount is greater than the Participant's remaining Contribution payments at the time of the qualifying event, taking into account all claims submitted before the date of the qualifying event. Such individual will be notified if the individual is eligible for COBRA continuation coverage.

If COBRA is elected, COBRA coverage will be subject to the most current COBRA rules. COBRA will be available only for the remainder of the Plan Year in which the qualifying event occurs. Such COBRA coverage for the **Health FSA** will cease at the end of the Plan Year, and cannot be continued for the next Plan Year. Coverage may terminate sooner if the Contributions for a Period of Coverage are not received by the due date established by the Plan Administrator for

that Period of Coverage. Continuation coverage is only granted after the Plan Administrator has received the Contributions for that Period of Coverage.

Contributions for coverage for **Health FSA** Benefits may be paid on a pre-tax basis for current Employees receiving taxable Compensation but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year, where COBRA coverage arises either:

- Because the Employee ceases to be eligible because of a reduction of hours; or
- Because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage.

For all other individuals, Contributions for COBRA coverage for **Health FSA** Benefits shall be paid on an after-tax basis, unless permitted otherwise by the Plan Administrator, but may not be prepaid from Contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year.

B.9 Qualified Reservist Distribution

If a Participant meets all of the following conditions, the Participant may elect to receive a qualified reservist distribution from the **Health FSA**:

- The Participant's Contributions to the **Health FSA** for the Plan Year as of the date the qualified reservist distribution is requested exceeds the reimbursements the Participant has received from the **Health FSA** for the Plan Year as of that date.
- The Participant is ordered or called to active military duty for a period of at least one hundred eighty (180) days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than one hundred eighty (180) days' duration must be supplemented by subsequent calls or orders to reach a total of one hundred eighty (180) or more days.
- The Participant is ordered or called to active military duty on or after April 1, 2009, or the Participant's period of active duty begins before April 1, 2009, and continues on or after that date.
- During the period beginning on the date of the Participant's order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the

Participant submits a qualified reservist distribution election form to the Plan Administrator.

Amount of Qualified Reservist Distribution. If the above conditions are met, the Participant will receive a distribution from the **Health FSA** equal to the Participant's Contributions to the **Health FSA** for the Plan Year as of the date of the distribution request, minus any reimbursements received for the Plan Year as of that date.

No Reimbursement for Expenses Incurred After Distribution Request. Once a Participant requests a qualified reservist distribution, the Participant forfeits the right to receive reimbursements for Health Care Expenses incurred during the period that begins on the date of the distribution request and ends on the last day of the Plan Year. The Participant may, however, continue to submit claims for Health Care Expenses that were incurred before the date of the distribution request (even if the claims are submitted after the date of the qualified reservist distribution), so long as the total dollar amount of the claims does not exceed the amount of the **Health FSA** election for the Plan Year, minus the sum of the qualified reservist distribution and the prior **Health FSA** reimbursements for the Plan Year.

Tax Treatment of a Qualified Reservist Distribution. If the Participant receives a qualified reservist distribution, it will be included in the Participant's gross income and will be reported as wages on the Participant's Form W-2 for the year in which it is paid.

B.10 Named Fiduciary

The Plan Administrator is the Named Fiduciary for the **Health FSA** for the purposes of Code Section 402(a).

B.11 Coordination of Benefits

Health FSAs are intended to pay Benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the **Health FSA** shall not be considered a group health plan for coordination of Benefits purposes, and the **Health FSA** shall not be taken into account when determining benefits payable under any other plan.

Schedule C
Dependent Care Flexible Spending Account

Unless otherwise specified, terms capitalized in this Schedule C shall have the same meaning as the defined terms in the Plan Document to which this Schedule is attached.

C.1 Benefits

An Employee can elect to participate in the **Dependent Care FSA** to receive Benefits in the form of reimbursements for Dependent Care Expenses. If elected, the Benefit Option will be funded by the Participant on a pre-tax Salary Reduction basis. Unless an exception applies, as described in the Irrevocability of Elections and Exceptions section above, such election is irrevocable for the duration of the Period of Coverage to which it relates.

C.2 Benefit Contributions

The annual Contribution for a Participant's **Dependent Care FSA** Benefits is equal to the annual Benefit amount elected by the Participant, subject to the Maximum Benefits paragraph below.

C.3 Eligible Dependent Care Expenses

Under the **Dependent Care FSA**, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

- **Incurred.** A Dependent Care Expense is "incurred" at the time the Qualifying Dependent Care Service giving rise to the expense is provided, and not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services.

- **Dependent Care Expenses.** Dependent Care Expenses means expenses that are considered to be:

  - Employment-related expenses under Code Section 21(b)(2) relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse; and

  - Expenses for incidental household services, if incurred by the Employee to obtain Qualifying Dependent Care Services, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through any other Plan.

  If only a portion of a Dependent Care Expense has been reimbursed elsewhere, the **Dependent Care FSA** can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Schedule.

- **Qualifying Individual.** A Qualifying Individual is:
    - A tax Dependent of the Participant as defined in Code Section 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code Section 152(a)(1);
    - A tax Dependent of the Participant as defined in Code Section 152, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
    - A Participant's Spouse, as defined in Code Section 152, who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

  In the case of divorced or separated parents, a child shall be treated as a Qualifying Individual of the custodial parent within the meaning of Code Section 152(e).

- **Qualifying Dependent Care Services.** Qualifying Dependent Care Services means services that both:
    - Relate to the care of a Qualifying Individual that enable the Participant and Spouse to remain gainfully employed after the date of participation in the **Dependent Care FSA** and during the Period of Coverage; and
    - Are performed:
        - In the Participant's home; or
        - Outside the Participant's home for:
            - The care of a Participant's Dependent who is under age 13; or
            - The care of any other Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant's household.

              In addition, if the expenses are incurred for services provided by a facility that provides care for more than six (6) individuals not residing at the facility and that receives a fee, payment or grant for such services, then the facility must comply with all applicable state and local laws and regulations.

- **Exclusions.** Dependent Care Expenses do not include amounts paid to or for:
    - An individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or Participant's Spouse;

- A Participant's Spouse;
- A Participant's child, as defined in Code Section 152(f)(I), who is under 19 years of age at the end of the year in which the expenses were incurred; and
- A Participant's Spouse's child, as defined in Code Section 152(a)(i), who is under 19 years of age at the end of the year in which the expenses were incurred.

C.4 Maximum Benefits

- **Maximum Reimbursement Available and Statutory Limits.** The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant's **Dependent Care FSA,** less amounts debited to the Participant's **Dependent Care FSA** pursuant to the Maximum Contribution paragraph below.

  Payment shall be made to the Participant as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this section have been satisfied.

  No reimbursement otherwise due to a Participant hereunder shall be made to the extent that such reimbursement, when combined with the total amount of reimbursements made to date for the Plan Year, would exceed the year to date amount of Participant Contributions to the **Dependent Care FSA** for the Period of Coverage or applicable statutory limit.

- **Maximum Dollar Limits.** The maximum dollar limit for a Participant is the smallest of the following amounts:
  - The Participant's Earned Income for the calendar year;
  - The Earned Income for the calendar year of the Participant's Spouse who:
    - Is not employed during a month in which the Participant incurs a Dependent Care Expense; and
    - Is either physically or mentally incapable of self-care or a Student shall be deemed to have Earned Income in the amount of Two Hundred Fifty and No/100 Dollars ($250.00) per month per Qualifying Individual for whom the Participant incurs Dependent Care Expenses, up to a maximum amount of Five Hundred and No/100 Dollars ($500.00) per month; or

- Seven Thousand Five Hundred and No/100 Dollars ($7,500.00) for the calendar year, if:
  - The Participant is married and files a joint federal income tax return; or
  - The Participant is married, files a separate federal income tax return, and meets the following conditions:
    - The Participant maintains as his or her home a household that constitutes, for more than half of the taxable year, the principal abode of a Qualifying Individual;
    - The Participant furnishes over half of the cost of maintaining such household during the taxable year; and
    - During the last six (6) months of the taxable year, the Participant's Spouse is not a member of such household; or
  - The Participant is single or is the head of the household for federal income tax purposes.
- Three Thousand Seven Hundred Fifty and No/100 Dollars ($3,750.00) for the calendar year if the Participant is married and resides with the Spouse, but files a separate federal income tax return.

- **Changes.** For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Salary Reduction Agreement or another document.

- **No Proration.** If a Participant enters the Plan mid-year or wishes to increase his or her election mid-year as permitted under this Plan, then the Participant may elect coverage or increase coverage respectively, up to the maximum annual Benefit amount stated above. The maximum annual Benefit amount will not be prorated.

- **Effect on Maximum Benefits If Election Change Permitted.** Any change in an election affecting annual Contributions to the **Dependent Care FSA** component will also change the maximum reimbursement Benefits for the balance of the Period of Coverage commencing with the election change effective date. Such maximum reimbursement Benefits for the balance of the Period of Coverage shall be calculated by adding:
  - The aggregate Contribution for the period prior to such election change; to
  - The total Contribution for the remainder of such Period of Coverage to the **Dependent Care FSA**; reduced by

- All reimbursements made during the entire Period of Coverage.

C.5 Establishment of Account

The Plan Administrator will establish and maintain a **Dependent Care FSA** with respect to each Participant who has elected to participate in the **Dependent Care FSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account so established will merely be a record keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's **Dependent Care FSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.

- **Debiting of Accounts.** A Participant's **Dependent Care FSA** will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

- **Available Amount is Based on Credited Amount.** The amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's **Dependent Care FSA**, less any prior reimbursements. A Participant's **Dependent Care FSA** may not have a negative balance during a Period of Coverage.

- **Use of Forfeiture**. All forfeitures shall be used by the Plan in the following ways:

  - First, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participant through Salary Reduction;

  - Second, to reduce the cost of administering the **Dependent Care FSA** during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and

  - Third, to provide increased Benefits or Compensation to Participants in subsequent years in any weighted or uniform fashion the Plan Administrator deems appropriate, and consistent with prevailing IRS guidance.

- **Unclaimed Benefits.** Any **Dependent Care FSA** Benefit payments that are unclaimed by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be applied as described above.

C.6 Reimbursement Procedure

- **Timing.** Within thirty (30) days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Dependent Care Expenses or the Plan Administrator will notify the Participant that a claim has been denied. This time period may be extended an additional fifteen (15) days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant forty-five (45) days from receipt of the written notice in which to complete an incomplete reimbursement claim.

- A Participant who has elected to receive **Dependent Care FSA** Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting a claim to HEI within ninety (90) days after the end of the Plan Year, setting forth:

  - The person or persons on whose behalf Dependent Care Expenses have been incurred;
  - The nature and date of the expenses incurred;
  - The amount of the requested reimbursement;
  - The name of the person, organization, or entity to whom the expense was or is to be paid;
  - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source;
  - The Participant's certification that he or she has no reason to believe that the reimbursement refunded, added to other reimbursements to date will exceed the limit herein; and
  - Other such details about the expenses that may be requested by the Plan Administrator.

  The Participant shall include bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the Plan Administrator may request.

- **Claims Denied.** For appeals of claims that are denied, see the Appeals Procedure in the Plan Document.

C.7 Reimbursements After Termination

When a Participant ceases to be a Participant under Section 4.3, the Participant's Salary Reductions and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant, or the Participant's estate, may claim reimbursement for any Dependent Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant, or the Participant's estate, files a claim within ninety (90) days after the end of the Plan Year following the date that the Participant ceases to be a Participant.

C.8 Dependent Care FSA Participant vs. Claiming the Dependent Care Tax Credit

Employees often have the choice between participating in their employer's **Dependent Care FSA** on a Salary Reduction basis or taking a Dependent Care Tax Credit under Code Section 21. Employees cannot take advantage of both tax benefit options. Employees with questions regarding which option is best should consult with an accountant.