GEORGE COUNTY BOARD OF EDUCATION CAFETERIA PLAN

PLAN DOCUMENT

Amended & Restated as of
01/01/2025

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ARTICLE 1 INTRODUCTION

Section 1.01 PLAN

The Plan Sponsor has established the George County Board of Education Cafeteria Plan (the "Plan"), 501, effective as of 01/01/2023 and amended and restated as of 01/01/2025.

The Plan is intended to qualify as a cafeteria plan within the meaning of Code section 125. The Plan provides for the payment and reimbursement of certain benefits offered under the Plan.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Employer on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Employer whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan as in effect from time to time prior to that date.

ARTICLE 2 DEFINITIONS

Account means
the bookkeeping balance of an account established for each Participant as of the applicable date. "Account" or "Accounts" shall include any account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Affiliate means
the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Benefits means
the benefit options available to Eligible Employees under the Plan.

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

Code means
the Internal Revenue Code of 1986, as amended from time to time.

Compensation means
the cash wages or salary paid to a Participant.

Contract means
an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. "Contract" shall not include any product which is advertised, marketed, or offered as long-term care insurance. "Contract" shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

Dependent means
an individual who qualifies as a dependent of a Participant under Code section 152 (as modified by Code section 105(b)). For purposes of the Premium Conversion Account, "Dependent" does not include any individual who is not a dependent under the underlying Contract. A child who is determined to be a Participant's alternate recipient under a qualified medical child support order under ERISA section 609 shall be considered a Dependent under this Plan, as applicable.

Dependent Care Assistance Plan Account or DCAP Account means
the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan in accordance with Article 7.

Effective Date means
01/01/2023, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

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Eligible Employee means
an Employee described in Section 3.01 of the Plan. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination. An individual who becomes employed by an Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the other entity shall not become eligible to participate in the Plan until the Employer or Plan Sponsor specifically authorizes such participation.

Employee means
any individual who is a common-law employee of an Employer, a leased employee as described in Code section 414(n), or full-time life insurance salesman as defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation.

Employer means
the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

ERISA means
the Employee Retirement Income Security Act of 1974, as amended from time to time.

General Purpose Health Flexible Spending Account or General Purpose Health FSA means
the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan.

Health Flexible Spending Account or Health FSA means
the General Purpose Health FSA and/or HSA-Compatible Health FSA established with respect to the Participant's election to have medical expenses reimbursed by the Plan.

Highly Compensated Employee means
an Employee described in Code section 414(q).

Highly Compensated Individual means
an individual within the meaning of Code section 105(h)(5).

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

HRA means
a health reimbursement arrangement subject to Code section 105.

Key Employee means
an Employee described in Code section 416(i).

Leased Employee means
an Employee described in Code section 414(n)(2).

Participant means
an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

Plan means
the George County Board of Education Cafeteria Plan.

Plan Administrator means
the person(s) designated pursuant to Section 9.01.

Plan Sponsor means
George County Board of Education, organized under the state laws of Mississippi.

Plan Year means
the 12-consecutive month period ending on 12/31.

Premium Conversion Account means
the Account established with respect to the Participant's election to have premiums reimbursed by the Plan.

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Qualified Plan means
the retirement plan sponsored by an Employer and identified in the plan.

Salary Reduction Agreement means
the agreement pursuant to which an Eligible Employee elects to reduce his or her Compensation and instead receive a Benefit provided under the Plan.

Termination and Termination of Employment means
any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3 ELIGIBILITY

Section 3.01 ELIGIBLE EMPLOYEES

An Eligible Employee is any Employee coincident with or next following the first day of the calendar month following the date the Employee has attained at least 18 years of age.

An Eligible Employee is any employee who is not an excluded employee. An excluded employee is any employee who is a Union Employee, Leased Employee, Nonresident Alien and part-time employee who is expected to work fewer than 0 hours per week.

An Eligible Employee may elect to participate in the Plan in accordance with Article 4. Eligible Employees who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date. Notwithstanding the foregoing, an Eligible Employee shall be eligible to make elections only for the Accounts as set forth herein.

Section 3.02 INELIGIBLE EMPLOYEES

The following Employees are not Eligible Employees and may not participate in any Benefit under the Plan: self-employed individuals (including partners), or persons who individually own (or are deemed to own) more than 2 percent of the outstanding stock of an Employer if it is an S corporation, or persons who are covered by a collective bargaining agreement that does not provide for participation in this Plan, leased employee, non-resident aliens who received no U.S. source earned income or part-time employee who is expected to work fewer than 0 hours per week. An Eligible Employee may be further modified by the provisions governing the applicable Benefit below.

Section 3.03 LEAVE OF ABSENCE

(a) *FMLA Leave of Absence.*

(1) *Health Benefits.* If the Employer is or becomes subject to FMLA and a Participant takes a leave of absence under FMLA, the Participant shall be entitled to continue to participate in those Benefits under the Plan that provides health care. If a Participant takes an unpaid leave of absence under FMLA, the Participant may elect, with respect to the Benefits that provide health care under the Plan, to continue coverage but discontinue payment of his or her contribution for the period of the FMLA leave of absence. If the Participant's contributions are suspended during the leave of absence, the Employer may recover the Participant's suspended contributions when the Participant returns to work from the FMLA leave of absence. Participants who choose to continue coverage for health benefits under a FMLA leave of absence may elect to: pre-pay on a pre-tax (to the extent permissible under Code section 125) or after-tax basis the contributions due for the FMLA leave of absence period prior to commencement of the FMLA leave of absence period; pay on an after-tax basis the same schedule as payments would have been made if the Participant were not on a leave of absence or if contributions were being made under COBRA and to the extent agreed in advance repay amounts advanced by the Employer to the Plan on behalf of the Participant upon return from the FMLA leave of absence.

(2) *Non-Health Benefits.* A Participant shall be entitled to continue to participate in Benefits under the Plan that do not provide health care in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. Participant contributions for Benefits during a leave of absence under FMLA shall be determined by the Plan Administrator in accordance with Code section 125.

(b) *Non-FMLA Leave of Absence*. If a Participant takes an unpaid leave of absence other than under FMLA, the Participant shall be entitled to continue to participate in Benefits under the Plan in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave.

(c) *Applicable State Law.* The Plan Administrator shall permit a Participant to continue Benefits under the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.

(d) *Paid Leave of Absence.* A Participant shall not be entitled to revoke participation in any Benefits during a paid leave of absence except in accordance with Article 4.

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(e) *USERRA.* If a Participant is on a leave of absence in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Participant shall be entitled to elect to continue participation in Premium Conversion Account and General Purpose Health Flexible Spending Account for the lesser of (i) 24 months, beginning on the date the Participant's absence began and (ii) the date the Participant fails to apply for or return to employment with the Employer, as determined under USERRA.

Section 3.04 TERMINATION OF PARTICIPATION

If a Participant remains an Employee but is no longer an Eligible Employee (e.g., due to a change in job classification), his or her participation in the Plan shall terminate on the last day of the month in which the Participant ceases to be an Eligible Employee.

Should such Employee again qualify as an Eligible Employee, he or she shall be eligible to participate in the Plan as of the first day of the subsequent Plan Year, unless earlier participation is required by applicable law or permitted in accordance with Section 4.03.

Section 3.05 TERMINATION OF EMPLOYMENT

If a Participant has a Termination of Employment, his or her participation in the Plan shall be governed in accordance with the terms of the applicable Benefit as provided herein.

Section 3.06 REEMPLOYMENT

(a) The Plan Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by an Employer within 30 days of a Termination.
(b) If an Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days following the date of Termination, the Plan Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of Termination or to make a new election under the Plan.
(c) *Ineligible Employees*. An Employee who has a Termination of Employment and who is subsequently reemployed by the Employer but is not an Eligible Employee shall be eligible to participate on the date the individual becomes an Eligible Employee and, at that time, may elect to participate in the Plan in accordance with Article 4.

ARTICLE 4 BENEFITS AND PARTICIPATION

Section 4.01 BENEFIT OPTIONS

Each Participant may elect to participate in the following Benefits, pursuant to the applicable Article herein:
(a) Premium Conversion Account
(b) General Purpose Health Flexible Spending Account
(c) Dependent Care Assistance Plan Account

Section 4.02 ELECTION TO PARTICIPATE

(a) *Elections to Participate*. The Plan Administrator shall prescribe such forms and may require such data from an Eligible Employee as are reasonably required and permitted under applicable law to enroll the Eligible Employee in the Plan or to effectuate any elections made pursuant to this Article 4. The Plan Administrator may adopt procedures governing the elections described in this Article 4, including, without limitation, a minimum annual and per pay period contribution amount, a maximum contribution per pay period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.
(b) *New Employees*. An Eligible Employee may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 30 days after the date the Eligible Employee becomes an Employee. The election will be effective as of the Employee's hire date; provided, however, that amounts used to pay for such election must be made from Compensation not yet currently available on the date of the election.
(c) *New Eligible Employees*. An Employee who becomes an Eligible Employee (for example, after satisfying the Plan's age and/or service requirements, if any) may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 31 days after the date the Employee becomes an Eligible Employee. The election will be effective on a prospective basis.
(d) *Continuing Eligible Employees.* An Eligible Employee may elect to enroll in the Plan or to modify or revoke his or her election during the period established by the Plan Administrator that precedes the Plan Year for which the election will be effective.
(e) *Failure to Elect*. If an Eligible Employee does not make an election in accordance with the required enrollment procedures with respect to any or all Benefits under the Plan, the Eligible Employee will be deemed to have elected not to participate in such Benefit for the applicable Plan Year, except as otherwise provided herein.

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Section 4.03 MID-YEAR ELECTION CHANGES

An Eligible Employee's election to participate in a Benefit hereunder is irrevocable during the Plan Year and may not be changed or revoked for any reason, except that an Eligible Employee may change his or her election during the Plan Year no later than the end of the 31-day period beginning on the date of a Change in Status (as defined below). The election change must be on account of and correspond with a Change in Status that affects eligibility for coverage under the Plan.

A Change in Status means the following:

(a) *Legal Marital Status.* Events that change an Eligible Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.

(b) *Number of Dependents.* Events that change an Eligible Employee's number of Dependents, including birth, death, adoption, and placement for adoption.

(c) *Employment Status.* Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's spouse, or the Eligible Employee's Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer of the Eligible Employee or the Eligible Employee's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the applicable plan, then that change constitutes a change in employment under this paragraph (c).

(d) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) *Residence.* A change in the place of residence of the Eligible Employee or the Eligible Employee's spouse or Dependent.

(f) *COBRA.* If the Eligible Employee or the Eligible Employee's spouse or Dependent becomes eligible for continuation coverage under an Employer's group health plan as provided in Code section 4980B or any similar state law, the Eligible Employee may elect to increase contributions to his or her Premium Conversion Account under the Plan in order to pay for the continuation coverage.

(g) *Court Order*. A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for an Eligible Employee's child or for a foster child who is a Dependent of the employee. The Eligible Employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the Eligible Employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(h) *Entitlement to Medicare or Medicaid.* If an Eligible Employee or an Eligible Employee's spouse or Dependent who is enrolled in an Employer's accident or health plan becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective election change to cancel or reduce coverage of that Employee, spouse, or Dependent under the Employer-sponsored accident or health plan. In addition, if an Eligible Employee or an Eligible Employee's spouse or Dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase his or her coverage or the coverage of his or her spouse or Dependent, as applicable, under the Employer-sponsored accident or health plan.

(i) *Significant Cost or Coverage Changes*.

(1) *Automatic Changes.* If the cost of an Employer-sponsored Contract premium increases (or decreases) during a period of coverage and, under the terms of the Contract, Eligible Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Eligible Employees' elective contributions for the Plan.

(2) *Significant Cost Changes.* If the cost charged to an Eligible Employee for a Contract benefit package option significantly increases or significantly decreases during a period of coverage, the Plan may permit the Eligible Employee to make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, Eligible Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the accident or health plan if no other benefit package option is offered).

A cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Eligible Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Eligible Employees). This paragraph (i) applies in the case of the Dependent Care Assistance Plan Account only if the cost change is imposed by a Dependent care provider who is not a relative of the Eligible Employee as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2). This paragraph (i) does not apply to Health FSAs.

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(j) *Significant Curtailment Without Loss of Coverage.* If an Eligible Employee or an Eligible Employee's spouse and/or Dependent has a significant curtailment of coverage under a Contract during a period of coverage that is not a loss of coverage as described in paragraph (l) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Contract), the Eligible Employee may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. This paragraph (j) does not apply to Health FSAs.

(k) *Significant Curtailment With Loss of Coverage.* If an Eligible Employee (or an Eligible Employee's spouse or Dependent) has a significant curtailment that is a loss of coverage, the Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (k), a loss of coverage means:

(1) a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation);

(2) a substantial decrease in the medical care providers available under the Contract (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(3) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee or the Eligible Employee's spouse or Dependent is currently in a course of treatment; or

(4) any other similar fundamental loss of coverage as determined by the Plan Administrator's in its sole discretion.

This paragraph (k) does not apply to Health FSAs.

(l) *Addition or Improvement of a Benefit Package Option.* If the Plan or a Contract adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, an Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option. This paragraph (l) does not apply to Health FSAs.

(m) *Change in Coverage Under Another Employer Plan.* An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including another plan of the Employer or of another employer) if-

(1) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (a) through (n) of this section (disregarding this paragraph (m)(1)); or

(2) This Plan permits Eligible Employees to make an election for a Plan Year that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

This paragraph (m) does not apply to Health FSAs.

(n) *FMLA.* If a Participant contributes to the cost of such Benefit, he or she may revoke coverage or continue coverage but discontinue payment of his or her share of the cost of a Benefit that provides group health plan coverage (including a Health FSA) during the period of a leave of absence under FMLA. An Eligible Employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.

(o) *Loss of Coverage Under Other Group Health Coverage.* An Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent if the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in 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. This paragraph (o) does not apply to Health FSAs.

(p) *Revocation due to Reduction in Hours of Service.* A Participant may prospectively elect to cancel contribution for and payment of the Employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer-sponsored group health plan and (2) the revocation of the election of coverage under the Employer-sponsored group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(q) *Enrollment in a Qualified Health Plan.* A Participant may prospectively elect to cancel contribution for and payment of the employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant is eligible for a special enrollment period to enroll in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act ("Marketplace") or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

The Plan Administrator reserves the right to determine whether an Eligible Employee has experienced a Change in Status and whether the Eligible Employee's requested election is consistent with such Change in Status.

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ARTICLE 5 PREMIUM CONVERSION ACCOUNT

An Eligible Employee may elect to have a portion of his or her Compensation applied by the Employer toward the Premium Conversion Account. The Account established under this Article 5 is intended to qualify under Code sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 5.01 ELIGIBLE EMPLOYEES

All Employees are eligible to participate in the Premium Conversion Account, except as otherwise specified in Article 3.

Section 5.02 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the Premium Conversion Account in accordance with Article 4.

(b) *Contributions.* A Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Conversion Account shall be equal to the amount of the Participant's portion of the premium on the applicable Contract. If the amount of the Participant's portion of the applicable premium on the Contract increases or decreases, the Participant's contribution to the Premium Conversion Account will automatically be adjusted to reflect the increase or decrease. Amounts in a Premium Conversion Account may be used toward the following benefits:
(1) Health coverage under the Employer's group health plan
(2) Dental coverage under the Employer's group dental plan
(3) Vision coverage under the Employer's group vision plan
(4) Supplemental Benefits

(c) *Failure to Elect*. An Eligible Employee who affirmatively elected not to participate in the Premium Conversion Account for the Plan Year with respect to Employer-sponsored Contracts will not be enrolled in the Premium Conversion Account for any Plan Year until he or she affirmatively elects to participate in the Premium Conversion Account with respect to Employer-sponsored Contracts in accordance with Article 4.

Section 5.03 ELIGIBLE EXPENSES

A Participant's Premium Conversion Account will be debited for amounts applied to the Employee-paid portion of the applicable Contract premiums. The Plan Administrator will not direct the Employer to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

Section 5.04 TERMINATION OF EMPLOYMENT

Upon a Participant's Termination of Employment, the Participant's contributions to the Premium Conversion Account will cease. Coverage under the applicable Contract may continue in accordance with the terms of the Contract for the remainder of the period of coverage with respect to which the required Contract premium has been paid.

ARTICLE 6 GENERAL PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.01 IN GENERAL

An Eligible Employee may elect to participate in a General Purpose Health Flexible Spending Account in accordance with this Article 6. The General Purpose Health FSA established under this Article 6 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 6.02 ELIGIBLE EMPLOYEE

The Employees identified in Article 3 are eligible to participate in the General Purpose Health Flexible Spending Account. An Employee who is not eligible to participate in an Employer-sponsored group health plan is not eligible to participate in the General Purpose Health FSA. An Eligible Employee who has elected to participate in the HSA Benefit and/or the HSA-Compatible Health FSA Benefit is not eligible to participate in the General Purpose Health FSA Benefit under this Article 6.

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Section 6.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the General Purpose Health FSA and elect to have a portion of his or her Compensation contributed to a General Purpose Health FSA in accordance with Article 4. A General Purpose Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.
(b) *Contributions.* A Participant's General Purpose Health FSA will be credited with amounts withheld from the Participant's Compensation.
(c) *Failure to Elect*. An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a General Purpose Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 6.04 LIMITS

(a) The amount of an Eligible Employee's contribution to a General Purpose Health Flexible Spending Account shall not exceed the limitations set forth in Code section 125(i), as adjusted.

Section 6.05 ELIGIBLE EXPENSES

(a) *Debits from the General Purpose Health FSA.* A Participant's General Purpose Health FSA will be debited for expenses described in this Section 6.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the General Purpose Health FSA, less any reimbursements already disbursed from the General Purpose Health FSA, shall be available to the Participant at any time during the Plan Year without regard to the balance in the General Purpose Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.
(b) *Eligible Expenses*. A Participant may be reimbursed from his or her General Purpose Health FSA for expenses that are: (i) incurred in the Plan Year, (ii) incurred by the Participant, the Participant's spouse and dependents, if any, (iii) incurred while he or she is a Participant in the Plan, and (iv) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source. For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:
    (1) *Michelle's Law.* "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.
    (2) *Coverage of Adult Children*. Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday.

Section 6.06 REIMBURSEMENT

(a) *Period for Reimbursement*. The Plan Administrator shall direct the reimbursement from a Participant's General Purpose Health FSA for eligible expenses incurred during the Plan Year.
(b) *Period for Submitting Claims*. A Participant may submit a request for reimbursement from his or her General Purpose Health FSA during the Plan Year and no later than 30 days after the end of the Plan Year. The claim must be made in the manner required by the Plan Administrator.
(c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the General Purpose Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the General Purpose FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.
(d) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the General Purpose Health FSA for expenses that are reimbursable under both the General Purpose Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the General Purpose Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the General Purpose Health FSA have been paid.
(e) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible General Purpose Health FSA expenses.

Section 6.07 FORFEITURES

(a) *Forfeitures.* Any balance remaining in a Participant's General Purpose Health FSA at the end of any Plan Year subject to the carryover amount limit in subsection (b) below, shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (5) reallocate to participants on a uniform basis, and/or (6) any other use allowed under all applicable laws and regulations. If the General Purpose Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer.

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(b) *Carryovers.* Notwithstanding subsection (a), the Plan will carry over to the immediately following Plan Year up to the maximum amount permitted under the tax code of any amount remaining unused as of the end of the Plan Year in a Participant's General Purpose Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the General Purpose Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the Plan Year to which it is carried over. Any unused amount remaining in the General Purpose Health FSA in excess of the carryover limit will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the rollover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 6.08 TERMINATION OF EMPLOYMENT

Contributions to a Participant's General Purpose Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's General Purpose Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days after termination.

Section 6.09 QUALIFIED RESERVIST DISTRIBUTIONS

(a) A Participant may receive a distribution of the amount contributed to his or her General Purpose Health FSA as of the date of the Qualified Reservist Distribution request minus General Purpose Health FSA reimbursements received as of the date of the Qualified Reservist Distribution request. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.
(b) A Participant may submit General Purpose Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.
(c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 6.10 SEPARATE PLAN

Although described within this document, the General Purpose Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The General Purpose Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA.

ARTICLE 7 DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

Section 7.01 IN GENERAL

An Eligible Employee may elect to have a portion of his or her Compensation contributed to a Dependent Care Assistance Plan Account. The DCAP Account established hereunder is intended to qualify as a dependent care assistance program under Code section 129 and shall be interpreted in a manner consistent with such Code section.

Section 7.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the Dependent Care Assistance Plan Account.

Section 7.03 ENROLLMENT

(a) *Enrollment.* An Eligible Employee may enroll in the DCAP Account in accordance with Article 4.
(b) *Contributions.* A Participant's DCAP Account will be credited with amounts withheld from the Participant's Compensation.
(c) *Failure to Elect*. An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a DCAP Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 7.04 LIMITS

The amount of all contributions to a Participant's DCAP Account shall not exceed the limitations set forth in Code section 129(a)(2), as adjusted.

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Section 7.05 ELIGIBLE EXPENSES

(a) *Debits from the DCAP Account.* A Participant's DCAP Account will be debited for expenses described in this Section. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of the Participant's DCAP Account.

(b) *Eligible Expenses.* Participant may be reimbursed from his or her DCAP Account for Dependent Care Expenses that are: (i) incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Dependent Care Expenses (as defined below), provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.

(1) "Dependent Care Expenses" are expenses incurred for the care of a Qualifying Individual, as defined in Code section 21(b)(1) and generally includes either: (i) a Dependent who is under age 13, or (ii) the Participant's spouse or Dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are Dependent Care Expenses only if they allow the Participant to be gainfully employed. Dependent Care Expenses include expenses for household services and expenses for the care of a Qualifying Individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the Qualifying Individual stays overnight. Expenses described in this subsection (2) that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or Dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least eight hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

Section 7.06 REIMBURSEMENT

(a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's DCAP Account for eligible expenses incurred during the Plan Year. An individual who ceases to be a Participant in the Plan (due to Termination or any other reason) may spend down his or her unused DCAP Account expenses, and such individuals may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs to the extent the claims do not exceed the balance of the DCAP Account.

(b) *Period for Submitting Claims*. A Participant may submit a request for reimbursement from his or her DCAP Account during the Plan Year and no later than 30 days after the end of the Plan Year. The claim must be made in the manner required by the Plan Administrator.

(c) *Payment of Claims*. To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from DCAP Account. The Plan Administrator may provide that payments/reimbursements from the DCAP Account of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(d) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible DCAP Account expenses.

Any balance remaining in a Participant's DCAP Account at the end of the Plan Year shall be forfeited and shall remain the property of the Employer. Unused contributions to a DCAP Account may not be cashed-out or converted to any other taxable or nontaxable benefit.

Section 7.08 TERMINATION OF EMPLOYMENT

Contributions to a Participant's DCAP Account shall cease upon Termination of Employment. Any balance remaining in a Participant's DCAP Account on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 30 days after termination.

Section 7.09 SEPARATE PLAN

Although described within this document, the DCAP Account is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129. The DCAP Account is also a separate plan for purposes of ERISA, HIPAA, and COBRA.

ARTICLE 8 NONDISCRIMINATION

Section 8.01 NONDISCRIMINATION REQUIREMENTS

The following nondiscrimination requirements shall apply:

(a) *Cafeteria Plan.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate.

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(b) *Group Term Life.* The Plan may not discriminate in favor of Key Employees as to benefits provided or eligibility to participate with respect to any group term life insurance.
(c) *Health Flexible Spending Account.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate with respect to the Health FSA.
(d) *Dependent Care Assistance Plan Accounts.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to DCAP Accounts.

Section 8.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 9 PLAN ADMINISTRATION

Section 9.01 PLAN ADMINISTRATOR

(a) *Designation.* The Plan Administrator shall be the Plan Sponsor. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor. The Committee shall elect a chair and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents on its behalf. The Plan Administrator shall also be the Plan "administrator" as such term is defined in section 3(16) of ERISA and the "named fiduciary" of the Plan (only to the extent that the Plan is subject to ERISA).

(b) *Authority and Responsibility of the Plan Administrator.* The Plan Administration shall have total and complete discretionary power and authority:

(1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(2) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits under the Plan;

(3) to determine the amount and manner of any allocations hereunder;

(4) to maintain and preserve records relating to the Plan;

(5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(8) to determine all questions of the eligibility and of the status of rights of Participants;

(9) to adjust Accounts in order to correct errors or omissions;

(10) to determine the validity of any judicial order;

(11) to retain records on elections and waivers by Participants;

(12) to supply such information to any person as may be required; and

(13) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) *Procedures.* The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

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(d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) *Compensation.* The Plan Administrator shall serve without compensation for its services.

(f) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 9.02 INDEMNIFICATION

The Plan Sponsor shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegates) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA, to the extent that the Plan is subject to ERISA.

ARTICLE 10 AMENDMENT AND TERMINATION

Section 10.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or its delegate.

Section 10.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.
(b) A participating Employer may terminate its participation in this Plan upon (i) written notice to the Plan Sponsor of its intent to terminate participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an affiliate of the Plan Sponsor.

ARTICLE 11 CLAIMS PROCEDURES

Section 11.01 CLAIMS PROCEDURES

(a) *Non-Plan Claims.* Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or similar documentation.
(b) *Plan Claims.* A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.
(c) *Documentation.* A Participant or any other person requesting benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.
(d) *Health Flexible Spending Account Claims.* This subsection shall apply for any claim for benefits under the Health Flexible Spending Account.

(1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

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(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA after following the Plan's claims procedures, and (E): (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (D) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal remedies. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Health Flexible Spending Account must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

(e) *Other Plan Account Claims.* This subsection shall apply for any claim for benefits under Accounts that is not a health flexible spending account.

(1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, ordinarily within 90 days after receipt of the claim, unless the Plan Administrator determines additional time is required to make a determination.

(2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying the reason or reasons for such denial and an explanation of the steps that the Claimant must take if he wishes to appeal the denial.

(3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall rule on an appeal within a reasonable period of time, ordinarily within 60 days of receipt of the appeal, unless the Plan Administrator determines additional time is required to make a determination.

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(4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying the reason or reasons for such denial. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, Claimants must exhaust the Plan's claim procedures. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 11.02 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (b) offset other benefits payable hereunder.

ARTICLE 12 MISCELLANEOUS

Section 12.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 12.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 12.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.

(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Benefit or account other than as expressly authorized in the Plan.

Section 12.04 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

To the extent the Plan is not subject to ERISA, any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 12.05 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of Mississippi, to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 12.06 TAX EFFECT

The Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan.

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Section 12.07 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 12.08 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 12.09 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 12.10 TRANSFERS

Except as explicitly set forth herein, amounts may not be transferred between Accounts.

Section 12.11 COBRA

If the Plan or Benefit is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan or Benefit is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 12.12 CONFLICTS

In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions that must be satisfied to become covered, if any, the benefits Participants are entitled to receive and the circumstances under which coverage terminates.

Section 12.13 DEATH

If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her Dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

ARTICLE 13 HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article shall only apply in the event that the Health FSA under the Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 13.01 DEFINITIONS

For purposes of this Article, the following terms have the following meanings:

(a) Business Associate means
any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means
the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) Individual means
the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) Notice of Privacy Practices means
a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means
the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

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(f) Protected Health Information ("PHI") means
information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:
(1) is created or received by the Plan or the Plan Sponsor;
(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and
(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.
PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means
information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:
(1) names;
(2) any geographic information which is more specific than a five digit zip code;
(3) all elements of dates relating to a covered Individual (*e.g.*, birth date) or any medical treatment (*e.g.*, admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
(5) facial photographs or biometric identifiers (*e.g.*, finger prints); and
(6) any other unique identifying number, characteristic, or code.

Section 13.02 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:
(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;
(B) for auditing claims payments made by the Plan;
(C) to request proposals for services to be provided to or on behalf of the Plan; and
(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.
(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.
(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.
(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.
(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.
(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.
(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.
(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.
(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

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(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.
(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor as outlined in the Plan's HIPAA Policies and Procedures may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.
(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.
(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.
(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

Section 13.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) 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;
(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
(d) Report to the Plan any security incident of which it becomes aware.

The Plan Sponsor caused this Plan to be executed this _____ day of _____, 2024.

GEORGE COUNTY BOARD OF EDUCATION:

Signature: _____

Print Name: _____

Title/Position: _____

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