

SUMMARY PLAN DESCRIPTION

of the

ROLAND-STORY COMMUNITY SCHOOL DISTRICT CAFETERIA PLAN

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INTRODUCTION

Roland-Story Community School District (the "Employer") is pleased to sponsor an employee benefit program known as a "Cafeteria Benefits Plan" (the "Plan") for you and your fellow employees. The Plan is called a cafeteria benefits plan because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to pay for selected benefits by entering into a salary reduction arrangement by which you elect to pay for the benefits on a pre-tax basis instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary reduction. Alternatively, you may choose to pay for any of the available benefits with after-tax contributions on a payroll reduction basis.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the Plan and a brief description of your rights as a Participant (defined in Q-3); it is not a part of the official Plan documents. If there is a conflict between the Plan documents and this Summary Plan Description, the Plan documents will control.

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible Employees (defined in Q-3) to use funds provided through employee salary reductions to pay for benefits under the Plan with pre-tax dollars.

Q-2. What benefits are provided by the Plan?

The Plan includes the following three benefit plans:

- *Premium Payment Component*—permits an Employee to pay for his or her share of premiums (that is, contributions for the cost of coverage) for the Insurance Plan with pre-tax dollars. "*Insurance Plan"* means the plan providing benefits through one or more insurance policies that your Employer maintains for Employees, their Spouses, Dependents and other children until the end of the year in which the other children have attained age 26. Benefits provided under the Premium Payment Component are called *"Premium Payment Benefits"*;
- *Health Flexible Spending Arrangement (Health FSA)*—also called a medical expense reimbursement plan—permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-22) that are not otherwise reimbursable by insurance with pre-tax dollars. Benefits provided under the Health FSA are called *"Health FSA Benefits";* and
- *Dependent Care Assistance Program (DCAP)*—also called a dependent care flexible spending account—permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined in Q-33) with pre-tax dollars. Benefits provided under the DCAP are called "*DCAP Benefits."*

Q-3. Who can participate in the Plan?

Employees of Roland-Story Community School District are eligible to participate in the Plan provided that the election procedures in Q-5 are followed.

In addition to satisfying the above eligibility conditions, an individual must also have met the eligibility conditions for the Employer's group medical plan in order to be eligible to participate in the Health Flexible Spending Account benefit described in this Summary Plan Description. Actual coverage under the Employer's group medical plan is not required.

"*Employee"* means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, except that the term does not include any common-law employee who is a leased employee, or any common-law employee classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee. "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency.

Those Employees who actually participate in the Plan are called "*Participants."* An Employee continues to participate until (a) the end of the Plan Year for which the election to participate was made unless the Participant elects during the *Open Enrollment Period* (defined in Q-6) to continue (or to discontinue) participation; (b) the termination of the Plan; (c) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or for any other reason), except that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the current Plan Year); or (d) the Participant revokes his or her election, as described in Q-7.

Q-4. What tax savings would I gain by participating in the Plan?

You save both federal income tax and FICA (Social Security) taxes by participating in the Plan. Following is an example of the tax savings you might experience as a result of participating in the Plan.

Suppose that you are married and that you file a joint tax return with your spouse, who earns no income. Lets also suppose that your share of the premiums for the benefits that you elect to receive over the course of a year totals $4,400. Your gross pay is $75,000 and your spouse (a student) earns no income and you file a joint tax return.

As illustrated in the table on the next page, your annual take-home pay would be $59,233 if you pay for the premiums on an after-tax basis, and $60,098 if you pay for the benefits on a pre-tax basis, an increase in take-home pay of $865. This is because by participating in the Cafeteria Plan, you will be considered for tax purposes to have received $70,600 in gross pay. There may be state tax savings, too. (How much you will actually save will depend on your total family income and other factors.)

Caution: The amount of the contributions used in this example is not meant to reflect your actual contributions. The actual contribution amounts will be described in a document provided separately to you by the Employer.

TABLE OF TAX SAVINGS[1]

		Cafeteria Plan	No Cafeteria Plan
1.	Adjusted Gross Income	$75,000	$75,000
2.	Salary Reduction for Premiums	($4,400)	$0
3.	W-2 Gross Wages	$70,600	$75,000
4.	Standard Deductions	($24,800)	($24,800)
5.	Taxable Income (line 3-4)	$45,800	$50,200
6.	W-2 Gross Wages	$70,600	$75,000
7.	Federal Income Tax	($5,101)	($5,629)
8.	FICA Tax (7.65% of line 3)	($5,401)	($5,738)
9.	After-Tax Premium Payments	$0	($4,400)
10.	Pay After Taxes and Premium Payments (line 6 less lines 7,8 and 9)	$60,098	$59,233

Some Benefits may Be Taxed. If you elect Group Term Life Insurance Benefits on a pre-tax basis in excess of the amount that qualifies for non-taxable treatment under the Code, the excess value of such Benefits will be treated as taxable income. If you elect Long Term Disability Insurance Benefits on a pre-tax basis, the value of all such Long Term Disability Insurance Benefits will be treated as taxable income.

Q-5. How do I become a Participant?

After you complete the eligibility requirements described in Q-3, you become a Participant by signing an individual Election Form/Salary Reduction Agreement on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You must complete the Election Form/Salary Reduction Agreement and turn it in to the Employer within the time period specified by the Administrator of the Plan (*Administrator*) in the enrollment materials. If you do not complete an Election Form/Salary Reduction Agreement and turn it in to the Employer within the specified period you will be deemed to have elected to have your insurance premiums (if any) paid with pre-tax salary reductions. You will not be able to participate in the other portions of the Plan until the next Open Enrollment Period (unless a *Change in Election Event* occurs, as defined in Q-7).

An Election Form/Salary Reduction Agreement will be made available to you by the first day of each Open Enrollment Period, and you will be given the opportunity during the Open Enrollment Period to elect your coverage for the 12 months beginning on the fist day of the next Plan Year. A Participant who fails to complete, sign and file an Election Form/Salary Reduction Agreement as required will be deemed to have made the same Premium Payment Component elections as were made for the prior Plan Year but will not be able to participate in the Health Flexible Spending Arrangement or the Dependent Care Assistance Program until the next Open Enrollment Period (unless a *Change in Election Event* occurs, as defined in Q-7).

[1] The standard deduction and federal income tax rates for 2020 as found in Rev. Proc. 2019-44, 2019-47 I.R.B. 1093.

Q-6. What is the "Open Enrollment Period?

You will be notified of the duration of the Open Enrollment Period. The Open Enrollment Period for a Plan Year generally will be the two month period prior to the beginning of the new Plan Year for that benefit component.

Q-7. Can I change my election for benefits or salary reduction amounts during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the salary reduction amounts you have selected during the Plan Year (known as the irrevocability rule), except that your election will terminate if you are no longer eligible under the Plan (see Q-8). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but that will apply only for the upcoming Plan Year.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events.* "Change in Election Events" include the following events, as more fully described below: Leaves of absence, including FMLA leave (defined in Q-14); Change in Status; certain judgments, decrees and orders; Medicare and Medicaid; Change in Cost; and Change in Coverage. (*Changes in Status, Cost* and *Coverage* are defined below). However, the Change in Election Events do not apply for all Benefits—exclusions are described below for each such Event.

If a Change in Election Event (including a Change in Status) occurs, you must inform the Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days of the occurrence, unless otherwise indicated.

1. Leaves of Absence (*Applies to Premium Payment, Health FSA and DCAP Benefits).* You may change an election under the Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. Change in Status. *(Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, and to DCAP Benefits.)* If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). "*Spouse"* means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code *(Code)*;
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code and other children of yours until the end of the year in which they attain age 26;
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a

reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be eligible for a particular employee benefit;

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, student status, or similar circumstance); and
- a change in your, your Spouse's or your Dependent's place of residence.

3. Change in Status—Other Requirements. *(Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, and to DCAP Benefits.)* If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined in Q-33) for the dependent care tax exclusion). Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent: change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage on account of attaining a certain age, etc. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change the employee-plus-one-dependent coverage would be consistent with this Change in Status. However, Mike could drop his Health FSA coverage completely.

However, if you, your Spouse, or a Dependent elect COBRA continuation coverage (as described in Q-12) under the Employer's plan for any reason other than divorce, annulment or legal separation, or your child's ceasing to be a Dependent, and you remain a Participant under the terms of this Plan, you may be able to increase your contribution to pay for such coverage.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only if* coverage for that individual becomes effective or is increased under the other employer's plan.
- *DCAP Benefits.* With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (1) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under an employer's Plan; or (2) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

4. Special Enrollment Rights. *(Applies to Premium Payment Benefits, but Not to Health FSA or DCAP Benefits.)* If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 *(HIPAA*) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in your Employer's health Insurance Plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect major medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within 30 days after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly-acquired Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Please refer to the summary plan description of the health Insurance Plan for an explanation of special enrollment rights.

5. Certain Judgments, Decrees and Orders. *(Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits.)* If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as

your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.

6. Medicare or Medicaid and State Children's Health Insurance Program. *(Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid or a State Children's Health Insurance program, you may cancel that person's accident or health coverage under the health Insurance Plan and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid or a State Children's Health Insurance program loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage, and/or begin or increase Health FSA coverage. Election changes must be made within 60 days of the applicable event.

7. Change in Cost. *(Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.)* If the Administrator notifies you that the cost of your coverage under the Plan *significantly* increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the Plan of your Spouse's employer; or (c) drop your coverage, but *only if* there is no option available under the Plan that provides similar coverage. (Note that, for purposes of this definition, (a) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA, (b) the HMO and the PPO are considered to be similar coverage, and (c) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage.) For *insignificant* increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.

> ***Example:*** Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, then Mike may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option. (He cannot drop his indemnity coverage without electing coverage under the HMO, because the HMO is a benefit package option that provides similar coverage.)

The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage. *(Applies to Premium Payment and DCAP Benefits, but Not to Health FSA Benefits.)* You may also change your election for the Plan if one of the following events occurs:

- *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of coverage (for example, the HMO ceases to be available where you live), then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the Plan of your Spouse's employer, or drop coverage but *only if* there is no option available under the plan that provides similar coverage.

- *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the health Insurance Plan.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.
- *DCAP Coverage Changes.* You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage.

Additionally, the Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See Q-12 and the booklets for the Insurance Plan for information on your right to continued or converted group health coverage after termination of your employment and see Q-24 for the deadline for filing claims for Health FSA benefits and Q-35 for the deadline for filing claims for DCAP benefits. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction in hours, you will become eligible to participate again in the Plan immediately upon satisfying the eligibility requirements.

Q-9. Will I pay any administrative costs under the Plan?

You may be required by your Employer to pay a portion of the costs of administering the Plan. Any such payments may be considered part of the Plan and may be pre-tax if deducted from your Compensation. Any remaining cost is paid in part by the use of forfeitures, if any (see Q-26 and Q-37). The rest of the cost of administering the Plan is paid by the Employer.

Q-10. How long will the Plan remain in effect?

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

Q-11. What happens if my claim for benefits is denied?

Insurance Plan Claims. If your claim is for a benefit under the Insurance Plan, you will generally proceed under the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for that plan or policy.

Claims Under the Plan. However, if (a) a claim for reimbursement under the Health FSA or DCAP Components of the Plan is wholly or partially denied, or (b) you are denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Salary Reduction Plan Document), then the claims procedure described below in this Q-11 will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Administrator within 30 days of the date the Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Administrator is expected to be made. Where a claim is incomplete the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information.

Appeals by Participant. If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the *Committee* (the Benefits Committee that acts on behalf of the Administrator with respect to appeals). Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decisions on Review. Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on the review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

a. the specific reason (s) for the decision on review;
b. the specific Plan provision(s) on which the decision is based;
c. a statement of your right to review (upon request and at no charge) relevant documents and other information; and
d. 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 to you upon request.

Q-12. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your Spouse's and Dependents' right, to continue the same coverage under any component medical benefit plan that was in place the day before a *Qualifying Event* if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation coverage under federal law is provided under *COBRA* (Consolidated Omnibus Budget Reconciliation Act of 1985) if your Employer is subject to COBRA.

A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your Spouse;
- your becoming entitled to receive Medicare benefits; or
- your dependent or child ceasing to be a dependent or otherwise eligible for coverage.

For a Qualifying Event other than a change in your employment status or death, it will be your obligation to inform the Administrator of the qualifying event within 60 days of its

occurrence. The Administrator, in turn, will furnish you (and your Spouse, as the case may be) with separate, written options to continue the coverages provided at stated premium costs with respect to each health plan in which you are participating. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage. You may pay premiums for COBRA coverage under your health Insurance Plan on a pre-tax basis (unless permitted otherwise by the Administrator on a uniform and consistent basis) to the extent compensation is available, but not beyond the current Plan Year.

Certain Participants with Health FSA Benefits will be eligible for COBRA Continuation Coverage if they have positive Health FSA Account (defined in Q-18) balances at the time of a Qualifying Event (taking into account all claims submitted before the date of the qualifying event). You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the Health FSA Account will cease at the end of the year and cannot be continued for the next Plan Year. You may pay premiums for such coverage on an after-tax basis (unless permitted otherwise by the Administrator on a uniform and consistent basis), but not beyond the current Plan Year).

You Must Give Notice of Some Qualifying Events - For some qualifying events (divorce or legal separation of you and your spouse or a child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Roland-Story Community School District
1009 Story Street
Story City, IA 50248

Q-13. How will participating in the Plan affect my Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your health Insurance Benefits and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the premium to the extent you opt to continue coverage). Your Employer may elect to continue all health Insurance Benefits and Health FSA Benefits coverage for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and you opt to continue your health Insurance Benefits and Health FSA Benefits, then you may pay your share of the premium in one of three ways: (1) with after-tax dollars while on leave; (2) with pre-tax dollars to the extent you receive compensation during the leave, or by pre-paying all or a portion of your share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation would normally be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (3) by other arrangements agreed upon between you and the Administrator (for example, the Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue health Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, as you and the Administrator may agree.

If your health Insurance Benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such Benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by the FMLA. You are entitled to have coverage for such Benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be entitled to elect whether to be reinstated in the Health FSA Benefit 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 you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave. If that policy permits Participants to discontinue contributions while on leave, Participants will upon returning from leave be required to repay the premiums not paid by the Participant during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Administrator and the Participant or as the Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility, see Q-7.

Q-15. What are "Premium Payment Benefits"?

If you elect Premium Payment Benefits, you will be able to pay for your share of insurance premiums with pre-tax dollars by entering into an Election Form/Salary Reduction Agreement with your Employer. This means that the share of the premiums you pay will be with pre-tax funds, which saves you Social Security and income taxes on the amount of your salary reduction.

Contact your Employer for a list of the Insurance Plan benefits offered under your Plan.

Q-16. How are my Premium Payment Benefits paid?

If you select the Insurance Plan described in Q-15, you may be required to pay a portion of the premiums for the Premium Payment Benefits that you have selected, as described in documents furnished separately to you. When you complete the Election Form/Salary Reduction Agreement, you specify that your share of the premiums will be paid with that portion of gross income that you have elected to give up through pre-tax salary reductions. From then on, you must pay a premium for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, unless otherwise agreed with, or as deemed appropriate by the Administrator). The Employer will not be liable to you if any insurance company fails to provide any of the insurance benefits.

The Employer may contribute all, some or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Q-17. What are "Health FSA Benefits"?

If you elect Health FSA Benefits, you provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Under that Agreement, you agree to a salary reduction to fund Medical Care Expenses instead of receiving a corresponding amount of your regular pay. This means that the premiums you pay will be paid with pre-tax funds. In return, you may be reimbursed from the Plan for certain eligible Medical Care Expenses. This arrangement helps you because the coverage you elect is nontaxable, which saves you Social Security and income taxes on the amount of your salary reduction.

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

Q-18. What is my "Health FSA Account"?

If you elect Health FSA Benefits, an account called a *Health FSA Account* will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the premiums that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-19. What are the maximum and minimum Health FSA Benefits that I may elect?

The maximum and minimum Health FSA benefit that you may elect for a Plan Year will be communicated to you each year in the Election Form/Salary Reduction Agreement and/or enrollment materials. If you elect to receive Health FSA benefits and the Plan imposes a minimum Health FSA election, that minimum will also be communicated to you each year. You may choose any amount of Medical Care Expenses reimbursement within these limits.

The total amount of Health FSA Benefits that you can purchase with pre-tax salary redirections is limited by law. For 2021 this limit is $2,750.00. This limit will be adjusted in subsequent years for inflation.

Q-20. How do I elect Health FSA Benefits?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to receive. From then on, you must pay a premium for such coverage by having an equal portion of the annual election amount deducted from each paycheck (unless otherwise agreed with, or as deemed appropriate by, the Administrator).

Q-21. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of the coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for eligible Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the premiums.) For example, suppose that you elected $1,200.00 of Health FSA benefits. During the first two months of the Plan Year the total contributed would be $200.00 ($100.00 per month times two months). You haven't made any prior claims for reimbursement during the calendar year, but you now incur a Medical Care Expense in the amount of $300.00. So long as the claim meets all applicable requirements, then $300.00 would be available to you for that expense, even though only $200.00 has been contributed to your Health FSA Account at the time.

Q-22. What are "Medical Care Expenses"?

"Medical Care Expense" means expenses incurred by you, your Spouse, your Dependents or any of your children (until the end of the calendar year in which the child attains age 26) for "medical care" as defined in Code § 213. Generally, this means an item for which you could have claimed a Medical Care Expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or could be reimbursed from insurance or from some other source.

You can also receive reimbursement for "over-the-counter" drugs that were purchased on or after January 1, 2020. This is a change from the law that was in effect prior to 2020.

For more information about what items are—and are not—deductible Medical Care Expenses, consult IRS Publication 502 (Medical and Dental Expenses), under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out their tax deductions, not to explain what is reimbursable under a Health FSA. So, some of the statements

in the Publication aren't correct when determining whether that same expense is reimbursable from your Health FSA. (For example, the Publication says that you may get a deduction based on when you "pay for" an expense. This rule does not apply to your Health FSA, which requires that you "incur" the expenses during the year—it does not matter when you pay for it. See Q-23. Also, for example, although health insurance premiums founders' fees, lifetime care, long-term contracts and long-term care services are listed as deductible expenses in Publication 502, they generally cannot be reimbursed from your Health FSA.) Be sure to ask the Administrator for help if you have any doubts about which expenses are—and are not—reimbursable.

Q-23. When are Medical Care Expenses incurred?

For Medical Care Expenses to be reimbursed to you, they must have been incurred during the Coverage Period. A Medical Care Expense is *incurred* when the service that gives rise to the expense is provided, not when the Expense was paid. Note that if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose. For example, if you pay for medical care on the first day of the month for care given on the 15th of that month, the expense has not been incurred until the 15th of that month. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Coverage Period, or after a separation from service (except for Continuation Coverage, as described in Q-12).

The Coverage Period for Health FSA Benefits is the Plan Year plus a 2½ calendar month "grace period" after the end of the Plan Year. This means, for example, that if you have not used up all of your Health FSA balance by the end of the Plan Year, you have an additional 2½ months after the end of the Plan Year to incur additional expenses. To be valid, all claims (including any claims for expenses that were incurred during the 2½ month "grace period") must be submitted within three calendar months of the end of the Plan Year. Any claims for expenses during the "grace period" will first be paid out of any remaining balance from the prior year. Once this is used up, claims will be paid out of your current year balance.

Q-24. What must I do to be reimbursed for Medical Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Administrator on a *Medical Reimbursement Request Form* that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred, and the amount of such Medical Care Expenses along with the Medical Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay.

If you have paid the premiums for the Health FSA coverage you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Medical Reimbursement Request Form (subject to a 15-day extension for matters beyond the Administrator's control—see Q-11). Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount you have elected.

You will have until the end of the third calendar month after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the

previous Plan Year. If your participation in the Plan terminates during a Plan Year, you will have 60 days following the date that your participation in the Plan terminates in which to submit a claim for reimbursement for Medical Care Expenses incurred prior to the date that your participation in the Plan terminated. You will be notified in writing if any claim for benefits is denied. (See Q-11).

To have your claims processed as soon as possible, please read Q-11. Please note that it is *not* necessary for you to have actually paid the bill in an amount due for a Medical Care Expense—only for you to have *incurred* the expense (as defined in Q-23), and that it is not being paid for or reimbursed from any other source.

Q-25. What if the Medical Care Expenses I incur during the Plan Year are less than the annual amount that I elected for Health FSA Benefits?

You will not be entitled to receive any direct or indirect payment of any amounts that have not been used to pay Medical Care Expenses that you have incurred. Any remaining amount will be forfeited as described in Q-26.

Q-26. When would I risk forfeiting my Health FSA Benefits?

You will forfeit any amount allocated to your Health FSA Account if that amount has not been applied to Health FSA Benefits for any Plan Year by the end of the third calendar month following the end of the Plan Year for which the election was effective. In addition, you will forfeit all remaining amounts allocated to your Health FSA Account on the date 60 days following the date that your employment terminated if your participation in the Plan ended during the Plan Year.

Amounts so forfeited shall be applied as described in the Plan (for example, used to offset Health FSA administrative expenses and future costs). Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described in the Plan.

Q-27. Will I be taxed on the Health FSA Benefits I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, you will be required to repay the amount. Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. You may wish to consult a tax advisor.

Q-28. What are "DCAP Benefits"?

If you elect DCAP Benefits, you provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Under that Agreement, you agree to a salary reduction to pay for Dependent Care Expenses instead of receiving a corresponding amount of your regular pay. This means that the premiums you pay will be with pre-tax funds. In return, you may be

reimbursed from the Plan for certain eligible Dependent Care Expenses. This arrangement helps you because the coverage that you elect is nontaxable, which saves you Social Security and income taxes on the amount of your salary reduction.

Q-29. What is my "DCAP Account"?

If you elect DCAP Benefits, an account called a *DCAP Account* will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the premiums that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer).

Q-30. What is the maximum DCAP Benefit that I may elect?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the maximum reimbursement amounts described below. You will be required to pay the annual DCAP "premium" equal to the coverage level you have chosen.

The amount of Dependent Care Expenses reimbursement that you choose cannot exceed the maximum amount specified in Code § 129. The maximum amount is currently $5,000 for a calendar year if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DCAP, your Spouse maintains a separate residence for the last six months of the calendar year, and you file a separate tax return; or
- are single or are the head of the household for tax purposes.

If you are married and reside with your Spouse, but you file a separate federal income tax return, then the maximum DCAP Benefits that you may elect is $2,500.00 for a calendar year.

The above maximum ($5,000.00 or $2,500.00 for a calendar year, as applicable) applies to the amount that you may elect under this Plan and any Plan of your Spouse. However, the above maximum is just the greatest amount that is possible; the election amount that applies to you may be less than the above maximum because of other limitations, as described in Q-33 (for example, note that reimbursement cannot exceed the amount of your or your Spouse's earned income for the Plan Year).

Q-31. How do I elect DCAP Benefits?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to receive. From then on, you must pay a premium for such coverage by having an equal portion of the annual election amount deducted from each paycheck (unless otherwise agreed with, or as deemed appropriate by, the Administrator).

Q-32. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. Suppose that you have elected $2,400.00 in

DCAP benefits and that you incur $1,500.00 of Dependent Care Expenses by the end of the first three months of the Plan Year. At that time, your DCAP Account would only have been credited with $600.00 ($200.00 times 3 months), so only $600.00 would be available for reimbursement (assuming that you had not received any prior reimbursements). You would have to wait to receive the remaining $900.00 of Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account.

Q-33. What are "Dependent Care Expenses"?

"Dependent Care Expenses" means employment-related expenses incurred on behalf of any Dependent who meets the requirements to be a *Qualifying Individual,* as defined in paragraph (a) below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

(a) Each Dependent for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
- a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
- your Spouse or a person who is your Dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.

(b) No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account. In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the Plan Year, would exceed the applicable statutory limit. Your applicable statutory limit is the smallest of the following amounts:
- your earned income for the calendar year (after your Salary Reductions under the Plan);
- the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of $200.00 ($400.00 if you have two or more Qualifying Individuals), for each month in which your Spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student); or
- either $5,000.00 or $2,500.00 for the calendar year, depending on your marital and tax filing status, as described further in Q-30).

(c) The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.

(d) The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: if your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.

(e) You (or you and your Spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a Qualifying Individual.

(f) The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.

(g) If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your Dependent under federal tax law; or (2) your Spouse or a person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.

(h) If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

(i) The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under Code § 151(c). If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.

(j) The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

For more information about what items are—and are not—deductible Dependent Care Expenses, consult IRS Publication 503 (Child and Dependent Care Expenses), under the heading "Tests to Claim the Credit." But use the Publication with caution, because it was meant only to help taxpayers figure out whether they can claim the Dependent Care Credit, not to explain what is reimbursable under a DCAP. So, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable from your DCAP. For example, regardless of what the Publication says, you must incur the expense during the Plan Year to get reimbursed for it. See Q-34. Be sure to ask the Administrator for help if you have any doubts about which expenses are—and are not—reimbursable.

Q-34. When must the Dependent Care Expenses be incurred?

Dependent Care Expenses must have been incurred during the Coverage Period. A Dependent Care Expense is *incurred* when the service that gives rise to the expense is provided; when the expense is paid is irrelevant. Note that if you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred for this purpose. For example, if you pay for your child's daycare on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Coverage Period, or after a separation from service (except as described in Q-35).

The Coverage Period for Dependent Care Benefits is the Plan Year plus a 2½ calendar month "grace period" after the end of the Plan Year. This means, for example, that if you have not used up all of your Dependent Care balance by the end of the Plan Year, you have an additional 2½ months after the end of the Plan Year to incur additional expenses. To be valid, all claims (including any claims for expenses that were incurred during the 2½ month "grace period") must be submitted within three calendar months of the end of the Plan Year. Any claims for expenses during the "grace period" will first be paid out of any remaining balance from the prior year. Once this is used up, claims will be paid out of your current year balance.

Q-35. What must I do to get reimbursed for my Dependent Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Administrator on a *Dependent Care Reimbursement Request Form* that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred, and the amount of such Dependent Care Expenses along with the Dependent Care Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the Dependent Care Reimbursement Request Form (subject to a 15-day extension for matters beyond the Administrator's control—see Q-11). If a claim is for an amount that is more than your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until the end of the third calendar month after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. If your participation in the Plan terminates during a Plan Year, you will have 60 days from the date that your participation in the Plan terminates to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the termination of your participation in the Plan or expenses incurred in the calendar month following the calendar month in which your employment terminates if such month is in the current Plan Year. You will be notified in writing if any claim for benefits is denied. (See Q-11).

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the bill in an amount due for Dependent Care Expenses—only for you to have *incurred* the expense (as defined in Q-34), and that it is not being paid for or reimbursed from any other source.

Q-36. What if the Dependent Care Expenses I incur during the Plan Year are less than the annual amount that I elected for DCAP Benefits?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Dependent Care Expenses that you have incurred and the annual coverage that you have elected and paid for. The difference will be forfeited as described in Q-37.

Q-37. When would I risk forfeiting my DCAP Benefits?

You will forfeit any amount allocated to your DCAP Account if that amount has not applied to DCAP Benefits for any Plan Year by the end of the third calendar month following the end of the Plan Year for which the election was effective. In addition, you will forfeit all remaining amounts allocated to your DCAP account on the date 60 days following the date that your participation terminated.

Amounts so forfeited shall be applied as described in the Plan (for example, used to offset reasonable administrative expenses and future costs). Also, any DCAP Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the end of the close of

the Plan Year following the Plan Year in which the Dependent Care Expense was incurred will be forfeited and applied as described in the Plan.

Q-38. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-30. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, you will be required to repay the amount. Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. You may wish to consult a tax advisor.

Q-39. If I elect DCAP Benefits, can I still claim the Dependent Care Credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the *balance* of your Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Code § 21 (*Dependent Care Credit*) (e.g., if you elect $3,000 of coverage under the DCAP and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5,000, you could count the excess $2,000 when calculating the Dependent Care Credit). Note: the amount of any Dependent Care Credit you may have available will be offset by any DCAP Benefits received under the Plan.

Q-40. What is the Dependent Care Credit?

As described in Q-39, the Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability under the Code. In determining what the tax credit would be assume that you may take into account only $3,000 of such expenses for one Dependent, or $6,000 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Dependent or $2,100 for two or more Dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one Dependent or $1,200 for two or more Dependents). The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

> **Illustration:** Assume that you have one Dependent for whom you have incurred Dependent Care Expenses of $3,600, and that your adjusted gross income is $20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more Dependents, your credit would have been $3,600 x 25% = $900, because the entire expense would have been taken into account, not just the first $3,000.

For more information about how the Dependent Care Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor.

Q-41. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Credit, instead of treating the reimbursements as tax-free?

Generally, if you are in one of the lower income tax brackets, you might come out ahead by not participating in the DCAP and by claiming the Dependent Care Credit instead. On the other hand, generally the more income taxes you are required to pay, the better it would be tax-wise to participate in the DCAP. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as a person's tax filing status (e.g., married, single, head of household), number of Dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you. You may also wish to consult a tax advisor.

Q-42. No Health Savings Account Benefits

The plan does not authorize pre-tax deposits to a Health Savings Account by either you or your Employer. If deposits are made to a Health Savings Account, such deposits are made on an after-tax basis.

Q-43. Reserved

Q-44. Reserved

Q-45. Reserved

Q-46. Reserved

Q-47. Reserved

Q-48. Reserved

Q-49. Reserved

Q-50. What are my Rights?

ERISA (the Employee Retirement Income Security Act of 1974) does not apply to this Cafeteria plan nor to any of its components. However, as a Participant, you are entitled to certain other rights and protections.

Your Rights. All participants shall be entitled to:

- Examine, without charge, at the administrator's 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 (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You have a right to continue your health Insurance Plan coverage (and, in some cases, your Health FSA coverage) for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights.

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

Assistance With Your Questions. If you have any questions about your plan, you should contact the Administrator. If you have any questions about this statement or about your rights, or if you need assistance in obtaining documents from the administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Q-51. What other general information should I know?

This Section contains certain general information that you may need to know about the Plan.

General Plan Information

- Roland-Story Community School District Cafeteria Plan is the name of the Plan.

The Plan Sponsor has assigned Plan Number 501 to your Plan.

- The provisions of the Plan described in this Summary Plan Description became effective on July 1, 2020.

- Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year for Medical Care Expenses and DCAP benefits begins on July 1 and ends on June 30. The Plan Year for Premium Payment Benefits begins on the renewal date of the insurance policies offered under the Insurance Plan and ends twelve months after that date.
- This is a welfare plan. Therefore, your benefits are not insured by the Pension Benefit Guaranty Corporation (PBGC), an agency of the federal government. The PBGC generally requires or provides insurance for certain pension plans only.

Plan Sponsor Information

- The Plan Sponsor's name and address are:

  Roland-Story Community School District
  1009 Story Street
  Story City, IA 50248
- The Plan Sponsor's federal employee tax identification number (EIN) is 42-0946175.

Plan Administrator Information

- The Plan Sponsor is the Plan Administrator.
- A third-party administrator processes claims for the Health FSA and DCAP Components of the Plan, but the Employer pays all claims out of its general assets. Benefits for the Health FSA and DCAP Components of the Plan are not paid from a trust or other fund. The name, address, and telephone number of the company that the Plan Sponsor has engaged to assist with the administration of the Plan are:

Advantage Administrators
100 2nd Street S.W.
P.O. Box 118
Waverly, Iowa 50677
Phone: (319) 352-1623 or (800) 383-1623
customercare@advantageadmin.com

Service of Legal Process

The Plan Sponsor is the Plan's agent for service of legal process. Legal process can be serviced on the Plan Sponsor at the address listed above.

Qualified Medical Child Support Order

The components of this Plan that are group health plans extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Administrator.

Newborns' and Mothers' Health Protection Act of 1996

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

may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Insurance Plan Documents

This Summary Plan Description does not describe the Insurance Plan. Consult the Insurance Plan documents and the separate Summary Plan Descriptions for any Insurance Plan benefits.