County of Yadkin
CAFETERIA PLAN

Plan Document and Summary Plan Description

Effective: July 01, 2023

ACS BENEFIT SERVICES

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION 3

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION 4

DEFINITIONS 6

ELIGIBILITY FOR COVERAGE; ENROLLMENT 9

TERMINATION OF PARTICIPATION; CONTINUATION OF COVERAGE 10

ELECTION OF BENEFITS 12

PREMIUM ONLY OPTION 16

HEALTH CARE FLEXIBLE SPENDING ACCOUNT OPTION 17

DEPENDENT CARE ASSISTANCE PROGRAM OPTION 19

PLAN ADMINISTRATION 22

CLAIM PROCEDURES; PAYMENT OF CLAIMS 24

MISCELLANEOUS 27

HIPAA PRIVACY 29

HIPAA SECURITY 33

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by County of Yadkin (the "Company" or the "Plan Sponsor") as of July 01, 2023, hereby sets forth the provisions of the County of Yadkin Cafeteria Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan pursuant to Code Section 125(d). This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of cafeteria plan coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

County of Yadkin

By: _____

Name: Lisa A. Hughes

Title: County Manager

Date: 6/8/2023

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established a "cafeteria plan" within the meaning of Code Section 125 for the benefit of eligible Employees and their eligible Dependents. This Plan is a voluntary employee benefit plan that affords a Participant the opportunity to take advantage of tax savings currently available. With this Plan, Employees can set aside a portion of income prior to it being taxed, as outlined herein.

The Plan is funded out of the general assets of the Employer based on salary reduction elections made by participating Employees.

General Plan Information

Name of Plan:
County of Yadkin Cafeteria Plan

Plan Sponsor:
County of Yadkin
217 E Willow St
Yadkinville, NC 27055
Phone: 1-336-849-7900

Plan Administrator:
(Named Fiduciary)
County of Yadkin
217 E Willow St
Yadkinville, NC 27055
Phone: 1-336-849-7900

Plan Sponsor ID No. (EIN):
56-6000352

Source of Funding:
Self-Funded

Applicable Law:
The Plan is intended to qualify as a cafeteria plan which meets the requirements of Code Section 125.

The Premium Only Option is not an employee benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

The Health Care Flexible Spending Account Option is intended to qualify as an accident or health plan under Code Sections 105 and 106.

The Dependent Care Assistance Program (DCAP) portion of the Plan is intended to qualify as a Dependent Care Plan under Code Section 129. This portion of the Plan is not an employee benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. An individual's rights as a Participant in the Plan are governed by the plan documents and applicable State law and regulations, as well as the above-described Code Sections.

Plan Year:
July 1 through June 30

Plan Type:
Premium Only Plan
Health Care Flexible Spending Account
Dependent Care Assistance Program (DCAP)

Claims Administrator:
ACS Benefit Services LLC
5660 University Parkway Fifth Floor
Winston-Salem, NC 27105
Phone: 1-336-714-1450
Fax: 1-336-759-0404
Email/Website: www.acsbenefitservices.com

Agent for Service of Process:
County of Yadkin
217 E Willow St
Yadkinville, NC 27055
Phone: 1-336-849-7900

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Discretionary Authority

To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

"Actively at Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" shall mean the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"Claims Administrator"
"Claims Administrator" shall mean the claims administrator which provides customer service and claims reimbursement services only and does not assume any financial risk or obligation with respect to those claims.

"Code"
"Code" shall mean the Internal Revenue Code of 1986, as amended.

"Dependent"
NOTE: *Domestic partners may be included in the definition of "Dependent", as defined within the Employer's medical plan, to the extent permissible under the Internal Revenue Code.*

"Dependent" for purposes of the Premium Only Option shall mean a Dependent as defined by the Employer-sponsored health plan(s), but in no circumstances (as required by Code Section 125), such Dependent shall not exceed the definition of a Dependent within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

"Dependent" for purposes of the Health Care Flexible Spending Account shall mean the following:

- The Employee's Spouse who (1) is recognized as a Spouse under the Code, (2) has met all the requirements of a valid marriage contract of the state or country in which the marriage of such parties was performed, and (3) has not legally separated or divorced from the Employee; and
- A Dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and
- Any child (as defined in Code Section 152(f)(1)) of the Employee who as of the end of the taxable year, has not attained age 27.

"Dependent" for purposes of the Dependent Care Assistance Program (DCAP) shall mean the Participant's children who are under the age of 13 and for whom the Participant is entitled to an exemption under Code Section 151(c); and a Spouse or Dependent of the Employee who is physically or mentally incapable of caring for himself, but for purposes of Dependent Care Assistance Program (DCAP) provisions, shall not

include an individual legally separated from the Employee under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Employee, files a separate federal income tax return, maintains a separate principal residence from the Employee during the last six months of the taxable year and does not furnish more than one-half the cost of maintaining the principal place of residence.

“Dependent Care”
“Dependent Care” shall mean dependent care expenses described in Dependent Care Assistance Program (DCAP).

“Dependent Care Assistance Program (DCAP)”
“Dependent Care Assistance Program (DCAP)” shall mean the account established pursuant to Dependent Care Assistance Program (DCAP) Section.

“Eligible Employee”
“Eligible Employee” shall mean any full time active Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an employer-employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered “full time”.

“Employee”
“Employee” shall mean an individual whom the Employer compensates for personal services performed on a regular and continuous basis and for whom the Employer pays employment taxes as required by the Code. "Employee" excludes self-employed individuals, independent contractors, partners in a partnership, and 2% shareholders of a Subchapter S corporation.

“Employer”
“Employer” shall mean County of Yadkin.

“Gainfully Employed”
“Gainfully Employed” for DCAP purposes shall mean working and earning an income as a result of that work, unemployed but actively seeking work, self-employed, a full-time student, or physically or mentally incapable of self-care.

“Health Care Flexible Spending Account” or “Health Care FSA”
“Health Care Flexible Spending Account” or “Health Care FSA” shall mean the account established pursuant to the Health Care Flexible Spending Account Section.

“HIPAA”
“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Incurred”
“Incurred” shall mean the date the service is rendered or the supply or expense is obtained and not when the Participant is formally billed, charged for, or pays for the service or care.

“Participant”
“Participant” shall mean an Employee who satisfies the eligibility and participation requirements specified in this document and is enrolled in the Plan.

“Plan Year”
“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Run-Out Period”
Run-Out Period” shall mean a period of up to 30 days days following the end of the Plan Year, during which claims applicable to the immediately preceding Plan Year may continue to be eligible for reimbursement under the Health Care FSA and DCAP. Claims submitted during the Run-Out Period shall be refunded from the prior Plan Year balance only.

“Spouse”
“Spouse” shall mean an Employee’s present spouse, thereby possessing a valid marriage license, not annulled or voided in any way, as outlined and defined within the Employer’s medical plan.

ELIGIBILITY FOR COVERAGE; ENROLLMENT

Eligibility Provisions

Each Employee will become eligible to participate in this Plan with respect to himself or herself on the first day of the month following date of hire.

Participation

Any Eligible Employee may elect to participate in this Plan. Participation in the Premium Only option is automatic unless waived.

Subsequent elections may be made annually during the election period as established by the Employer. Such open enrollment elections will become effective on the first day of the next Plan Year.

If an Employee does not complete the election form (either paper or electronic as applicable) on a timely basis, he or she will be considered to have elected not to participate in the Health Care FSA option, DCAP option, or Premium Only option of this Plan.

Rehire

An Employee who is terminated for any reason, including (but not limited to) layoff, voluntary resignation, disability, or retirement, and is rehired within 30 days or less will be reinstated with the same elections that such Employee had before termination.

An Employee who is terminated for any reason, including (but not limited to) layoff, voluntary resignation, disability, or retirement, and is rehired more than 30 days following termination may make new elections as of the date of hire.

TERMINATION OF PARTICIPATION; CONTINUATION OF COVERAGE

Termination of Participation

A Participant will cease to be a Participant in this Plan on the earliest to occur of the following dates:

- The date upon which the Plan is terminated, or with respect to any particular benefit, the date the benefit is terminated.
- The expiration of the Plan Year for which the Employee has elected to participate (unless during the open enrollment period for the next Plan Year the Employee elects to continue participating).
- The date of the month in which the Employee is no longer eligible (because of retirement, termination of employment, layoff, reduction in hours, death of an Employee, or any other reason) to participate.
- The date the Participant elects to terminate his or her participation pursuant to a permitted election change under the terms of this Plan in accordance with Section 125 and any other governing regulation.

Termination of Employment

If an Employee terminates employment during a Plan Year, all contributions to this Plan will cease as of the date of termination. An Employee will be entitled to submit claims for a period of 30 days after the end of the Plan Year. Employees participating in the Plan may elect to continue to participate as described below under Continuation of Coverage under COBRA.

Leave of Absence

If a Participant takes a leave of absence, paid or unpaid, he or she may still participate in the Plan. Options for continuing, suspending, or revoking participation in the Premium Only Option, Health Care Flexible Spending Accounts and Dependent Care Assistance Program (DCAP) will vary according to the leave status as Family and Medical Leave Act (FMLA) or non-FMLA.

The Participant should contact the Employer in advance of the leave for more information.

Health Care Flexible Spending Distributions for Reservists

In accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act), an Employee ordered or called to active duty may receive distributions of unused amounts in his or her Health Care FSA. A "qualified reservist distribution" (QRD) is permitted if:

- The individual is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period; and
- The request for distribution is made during the period beginning with the order or call to active duty and ending on the last day of the Plan Year that includes the date of the order or call to active duty.

The Employee must provide the Employer with a copy of the order or call to active duty. If the order or call specifies that the period of active duty is for 180 days or more or is indefinite, the Employee is eligible for a QRD, and the Employee's eligibility is not affected if the actual period of active duty is less than 180 days or is otherwise changed. If the period specified in the order or call is less than 180 days, a QRD is not allowed. However, subsequent calls or orders that increase the total period of active duty to 180 days or more will qualify an Employee for a QRD.

The amount available will be the amount contributed to the Health Care FSA as of the date of the QRD request minus Health Care FSA reimbursements received as of the date of the QRD request. No further

reimbursement will be made for medical expenses Incurred after the date a QRD is requested for the remainder of that Plan Year.

Continuation of Coverage under COBRA

NOTE: Only Participants in the Health Care FSA Option of the Plan are eligible to continue such coverage under COBRA. COBRA coverage is not required for Calendar Years in which an Employer or a Company has 20 or fewer employees.

Limited continuation of group health coverage for the balance of the Plan Year is required by federal law for Health Care FSA Participants who have underspent their accounts as of the qualifying event date, and it is the intent of this Plan to comply with federal law.

If an Employee participating in the Health Care FSA of the Plan terminates his or her employment or becomes ineligible because of reduced hours, he or she may continue to participate in a Health Care FSA on an after-tax basis by electing continuation of coverage under COBRA through the end of the Plan Year in which COBRA coverage commences. Continued participation will allow an Employee to submit, for reimbursement, expenses eligible for reimbursement through the Plan according to the provisions of the Plan after termination of employment. Continued participation will provide that an Employee be allowed the rights and privileges of similarly situated Employees, except that open enrollment will not be offered for another Plan Year.

Qualified beneficiaries may also include the Employee's Spouse and/or the Employee's Dependents. Qualifying events for non-Employees include the death of the Employee; the divorce or legal separation of the Employee from his or her Spouse; the Employee's becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the plan by him and his or her Dependents; and the loss of Dependent status by a Dependent child under the terms of this plan. Written notice regarding the right to COBRA must be provided to the designated COBRA Claims Administrator, if applicable. The notice must include the name of the Employee with identification number, Plan name and number, date and type of the qualifying event and name(s) of the applicable Dependent(s). Employees and Dependents who elect to continue coverage must pay the full cost of the plan, not to exceed 102% of the Employer's cost.

COBRA coverage is not available for Participants who have overspent their Health Care FSA as of the qualifying event date. If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law.

ELECTION OF BENEFITS

By accepting coverage under this Plan, an Employee and his or her Dependents agree to supply information about medical conditions and records when requested by the Plan. All private health information will be kept confidential and will be used on a need only basis for purposes of administering Plan benefits.

Contributions

An Eligible Employee will elect, unless he/she chooses to waive coverage, to contribute a portion of his or her salary to pay for eligible costs that will be Incurred during a Plan Year.

Use It or Lose It Rule

If an Employee has a balance in his or her Health Care FSA at the end of a Plan Year, it may be carried over, up to $610, into the subsequent Plan Year. Other than the permitted carryover amount, any balance that exceeds this amount at the end of the Plan Year must be forfeited. There is no minimum amount required for carry over.

Any balance in an Employee's DCAP at the end of must be forfeited.

Carryover

With the exception of the Health Care FSA, balance in an Employee's account at the end of a Plan Year must be forfeited. Under IRS rules for flexible spending account plans, that balance cannot be paid to an Employee in cash, carried over to the next Plan Year, nor be made available to an Employee in any way. Forfeited funds may be used to offset costs of the Plan.
If an Employee has a balance in his or her Health Care FSA at the end of a Plan Year, he or she may carry over up to $$610 into the subsequent Plan Year.

If an Employee participates in the Health Care FSA and carries over any amount to the following Plan Year, he or she will not be eligible to participate in the HSA in the following Plan Year.

Change in Elections

Pursuant to federal regulations an Employee may change his or her participation elections during the open enrollment period established by the Employer. Such changes may be made for any reason and will become effective on the first day of the next Plan Year.

During the remainder of the Plan Year, an Employee may not change his or her elections unless he or she experiences a qualifying change in his or her status that is on account of and consistent with the change, as discussed below.

Change in Status

The following events are changes in status:

- Legal Marital Status. Events that change an Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.

- Number of Dependents. Events that change an Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption; and court ordered change in custody or Qualified Medical Child Support Order (QMCSO).

- Employment status. Any of the following events that change the employment status of the Employee, the Employee's Spouse, or the 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 cafeteria plan or other employee benefit plan of the employer of the Employee, 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 that plan, then that change constitutes a change in employment (e.g., if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status).

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

- Residence. A change in the place of residence of the Employee, Spouse, or Dependent.

Consistency Rule. An election change satisfies the consistency rule only if the election change is ***on account of and corresponds with a change in status*** that affects eligibility for coverage under an employer's plan.

If an Employee experiences a change in status, he or she will be permitted to change his or her election in a manner that is consistent with the change in his or her status, provided that he or she does so within 30 days. Any such change will become effective on the date of the occurrence, the date that the change of election is received or the first of the month following the date of the change in election, as permissible by law.

Special Application of Consistency Rule to Dependent Care. IRS regulations provide that the consistency rule is satisfied for a DCAP if the election change is on account of and corresponds with a change in status that affects eligibility of DCAP expenses for tax exclusions. The following examples illustrate the effect of change in status and consistency rule requirements for a DCAP change in elections:

- A Dependent child's turning age 13 would affect eligibility for Dependent Care expenses. Therefore, a Dependent Care election may be canceled when a Dependent child turns age 13 in the middle of a Plan Year and is no longer a qualifying individual for purposes of the DCAP rules.

- An Employee's or Spouse's leave of absence (paid or unpaid) or change in employment status (part-time to full-time or vice versa) would also represent a special application of the consistency rule under a DCAP. A change in the number of hours of work performed by the Employee or the Employee's Spouse is a change in coverage. Thus, the Dependent Care election may be changed to correspond with the change in coverage.

- Another special application of the consistency rule under a DCAP provides that significant changes in the cost for the services of the child care provider represent a change in status that will permit a corresponding change in the Dependent Care election. However, no change based on a significant increase or decrease in cost can be made to a DCAP when the cost increase for Dependent Care is imposed by a Dependent Care provider who is a relative of the Employee.

Medicare or Medicaid Entitlement
If the Employee, the Employee's Spouse or qualified Dependent becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Employee may prospectively reduce or cancel his or her election. Likewise, if the Employee, the Employee's Spouse or qualified Dependent loses eligibility to Medicare or Medicaid coverage, then the Employee may prospectively elect to commence or increase his or her election.

Additional Mid-Year Changes for Non-Calendar Year Plan Due to Conflicting Open Enrollment Periods (Not Applicable for Health Care Flexible Spending Account Option)
In order for election changes to be permitted under this exception, the election change must be on account of, and correspond with, the change in coverage under the plan of the Spouse's, former Spouse's or

Dependent's employer. This Plan will permit elections for a period of coverage different from that under the plan of the Spouse's, former Spouses or dependent's employer.

Significant Cost or Coverage Changes (Not Applicable for Health Care Flexible Spending Account Option)

If an Employee's cost for coverage under the Employer-Sponsored health plan changes significantly during a Plan Year, the Employee may choose to revoke his or her election under the Premium Only Option and in its place receive on a prospective basis coverage under another plan providing similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether a substitute plan provides similar coverage. If the change in cost is deemed to be insignificant, each Employee's election shall be prospectively decreased or increased to reflect the change. Similarly, if a change in cost is significant but the Employee chooses not to revoke his or her election, that Employee's election shall be changed accordingly.

Furthermore, an Employee may revoke his or her election or make a prospective election change during the Plan Year if the change corresponds with an open enrollment period change made by the Employee's Spouse or qualified Dependent, provided that the Employee's election change is consistent with the changes made under the other group benefits plan and the other group benefits plan permits such an election change. Similarly, the Plan Administrator (in its sole discretion) will determine, based upon prevailing IRS guidance, whether the requested change is on account of and corresponds with a change made under the group benefits plan of the Spouse or qualified Dependent.

Furthermore, an Employee may revoke his or her election or make a prospective election change during the Plan Year if the coverage under his or her Employer-sponsored health plan is significantly curtailed or ceases during a period of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether coverage has been significantly curtailed.

Finally, an Employee who loses group health coverage under plans of governmental or educational institutions (including state children's health insurance programs, state health benefits risk pools, and health plans sponsored by foreign or Indian tribal governments and organization) may be permitted to enroll in the Employer's health care plan and make a prospective election change during the Plan Year. This applies to the Premium Only Option.

If an Employee's cost for Dependent care changes significantly during a Plan Year, the Employee may increase or decrease his or her contribution election to reflect the new fee, switch to an alternative or similar coverage option (i.e., a new provider) and make a corresponding election change, or revoke his or her election if no similar alternative coverage option is available. If a cost change is imposed by a Dependent care provider who is a relative (as defined in the regulations), no election change will be permitted.

If an Employee changes dependent day care providers during a Plan Year, a new election may also be permitted.

Reduction in Hours of Service

In accordance with Notice 2014-55, an Employee who is enrolled in the Employer's benefit plan and experiences a reduction in hours of service, as defined by ACA, may prospectively revoke coverage if the following conditions are met:

- The Employee has been in an employment status under which the Employee was reasonably expected to average at least 30 hours of service per week and there is a change in that Employee's status so that the Employee will reasonably be expected to average less than 30 hours of service, as defined in the Affordable Care Act, per week after the change, even if that reduction does not result in the Employee ceasing to be eligible under the group health plan; and
- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another health plan that provides minimum essential coverage, as defined in the Affordable Care

Act, 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.

An Employee exercising a revocation due to a reduction in hours of service must demonstrate intent or actual enrollment in another health plan. The Employee must certify in writing that the Employee, and his or her spouse and/or dependents whose coverage is being revoked, have enrolled or intend to enroll in another plan that provides minimum essential coverage, as defined in the Affordable Care Act, and that such coverage will be effective no later than the first day of the second month following the month that includes the date the original coverage under the Employer's group health plan is revoked.

Enrollment in a Qualified Health Plan Through an Exchange

An Exchange is also referred to as the Health Insurance Marketplace, hereinafter referred to as "Exchange."

In accordance with Notice 2014-55, an Employee who is enrolled in the Employer's group health plan may prospectively revoke coverage if the following conditions are met:

- The Employee must be eligible for a Special Enrollment Period to enroll in a qualified health plan through the Exchange pursuant to applicable guidance or the Employee is seeking to enroll in a qualified health plan through the Exchange during the Exchange's applicable annual open enrollment period; and
- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in a qualified health plan through the Exchange. Such coverage must be effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

An Employee exercising a revocation due to enrollment in a qualified health plan through the Exchange must demonstrate intent or actual enrollment in the Exchange coverage. The Employee must certify in writing that the Employee, and his or her spouse and/or dependents whose coverage is being revoked, have enrolled or intend to enroll in Exchange coverage and that such coverage will be effective no later than the day immediately following the last day of coverage on the Employer's group health plan.

PREMIUM ONLY OPTION

For an Employee enrolled in certain health care benefit plan(s) sponsored by the Employer, payroll deductions for contributions, including any change in the cost of the benefit during a period of coverage under the terms of the Plan, will be taken automatically before income is taxed for federal, applicable state and Social Security purposes, as allowed by law. The Employee's election for those contributions will continue year after year unless the Employee makes a change during the open enrollment period, or in the case of a qualified status change.

Information regarding the Employer-sponsored health plan(s) is contained in the plan documents and/or insurance contracts for those plans. Coverage and claims procedures for such health benefits are governed by said documents.

Eligible Expenses

A Premium Only Option allows Employer-sponsored premium payments to be paid by the Employee on a pre-tax basis instead of after-tax. Coverage may include the following:

- Health
- Dental
- Vision
- Disability – NOTE: If disability premiums are paid pre-tax, benefits received are subject to taxation. Therefore, it is typically preferential to apply taxes to the premiums.
- Employee Group Term Life (up to $ 50,000)
- Cancer
- Hospital Indemnity
- Accident

Cash in Lieu of Benefits

An individual may elect compensation in lieu of coverage. Contact the Plan Administrator for more details and any specific requirements.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT OPTION

Contributions

The maximum amount an Employee may contribute to his or her Health Care Flexible Spending Account during the 12 month Plan Year is $3,050 (pro-rated for enrollment periods of less than 12 months).

Eligible Expenses

In general, Health Care expenses for an Employee and his or her Dependents are eligible for reimbursement from his or her Health Care Flexible Spending Account if they meet all of the following requirements:

- The expenses were Incurred on or after the effective date of the Employee's participation in the Plan.
- They would qualify as medical expenses for federal income tax purposes under Code Section 213.
- They have not been and will not be paid by the Employee's health benefit plan(s) or by another employer's group health benefit plan or by any other insurance policy or program.
- They have not and will not be deducted on the Employee's tax return.

Eligible reimbursable expenses under this Plan include, but are not limited to, out-of-pocket expenses for:

- Deductibles and copayments for hospital, physician, prescription drug, dental and vision care.
- Uncovered health services such as hearing aids, vision care, routine physicals and well-baby care, counseling therapy and long-term rehabilitation services (alcoholism and drug abuse).
- Fees in excess of plan limits, including those for orthodontia and psychiatric services.

Under current laws the contributions a Spouse makes for health insurance and the expenses for elective cosmetic surgery are expenses which are not eligible for reimbursement from the Employee's Health Care Flexible Spending Account. These are just two examples of ineligible expenses.

Further information on the types of health care expenses eligible for reimbursement from an Employee's Health Care Flexible Spending Account is available from the IRS in Publication 502. (Call 1-800-TAXFORM.) However, Publication 502 provides information relating to tax-deductible expenses on the federal income tax return and; therefore, includes some provisions that conflict with this Plan. For purposes of filing a claim for reimbursement, all other terms and conditions of this Plan shall apply in determining the benefits available to a Participant.

Over-the-Counter Drugs

Notwithstanding the eligible expense requirements set forth above, Over-the-Counter (OTC) Drug expenses for an Employee and his or her Dependents are eligible for reimbursement from his or her Health Care FSA if they are medicines or drugs that are used for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Pursuant to Code Section 106(f), expenses incurred for menstrual care products shall be treated as incurred for medical care (as defined in Code Section 223(d)(2)(D)) and deemed an eligible expense. Items that are used to promote the general good health of an individual, such as vitamins, are not eligible for reimbursement. OTC drug medical expenses must be properly substantiated when filing a claim for reimbursement. Different levels of substantiation may be required depending on the facts and circumstances of the claim.

Debit Card Privileges

All Employees that elect to participate in the Health Care FSA benefit option may use a debit card to pay for eligible expenses that are Incurred during the Plan Year. The card is a prepaid debit card that may be used for purchases at certain merchant locations that accept debit cards. The card should only be used to pay for qualified health care expenses. The card cannot be used to get cash or to obtain cash back in any purchase transaction. If the card is used to pay for non-qualified purchases, the Employee must repay those

amounts to the Plan. For more detailed information about using the card, see the cardholder agreement with the debit card company.

Care Expenses

To determine how much an Employee should contribute, the Employee should estimate the unreimbursed health care expenses that are expected to be Incurred in the Plan Year ahead. Careful consideration should include anticipated medical, dental and vision care out-of-pocket expenses. Any balance in an Employee's Health Care FSA, in excess of $610 at the end of the Plan Year must be forfeited. A balance that is not in excess of $610 will be carried over for reimbursement if the subsequent Plan Year. Under IRS rules for flexible spending account plans, the forfeited amount cannot be paid to an Employee in cash, nor be made available to an Employee in any way. Forfeited funds may be used to offset costs of the Plan.

NOTE: As permitted by the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act), unused amounts in the Health Care Flexible Spending Account may be distributed if requested prior to the end of the Plan Year.

Coordination of Benefits; Health Reimbursement Arrangement (HRA) to Reimburse First

Benefits under this Plan are intended to reimburse only qualified medical expenses which are not reimbursable from any other source. If another source, including a Health Reimbursement Arrangement (HRA), is available to reimburse an otherwise eligible qualified medical expense, this Plan will reimburse said expense only as secondary to any and all available other sources.

DEPENDENT CARE ASSISTANCE PROGRAM OPTION

Contributions and Limitations

Contributions to an Employee's DCAP are limited by federal regulations. An Employee may elect to contribute a maximum to a DCAP during the Plan Year that is the **lesser of**:

- **$5,000** if the Participant is single and files an individual tax return or if the Participant is married and files a joint tax return;

- **$2,500** if the Participant is married and files a separate tax return; **or**

- The Participant's taxable income or the Spouse's taxable income, whichever is less. (For example, if the Employee earns $25,000 per year and his or her Spouse earns $3,000, then the Employee's contribution to a DCAP can be no more than $3,000 for the year.)

Maximum is pro-rated for enrollment period of less than 12 months.

Important: Contributions to all employer-sponsored DCAP plans cannot exceed $5,000 on a combined basis in any calendar year.

The payroll deductions will begin in the first payroll following submission of the Employee's election form (either paper or electronic as applicable) and the annual amount will be divided among the remaining paychecks for the Plan Year.

If a Participant's Spouse is a full-time student or cannot care for himself, the Spouse may be considered to have an income of **$250 per month** if there is one qualified Dependent or **$500 per month** if there are two or more qualified Dependents.

NOTE: The Child Care Tax Credit on a Participant's federal income tax statement provides a dollar-for-dollar write-off against the Participant's taxes. The Child Care Tax Credit cannot be used for expenses paid by the DCAP. The Tax Credit amount may range from 20% to 35% of child care costs dependent upon the Participant's adjusted gross income. The credit cannot be claimed on more than the amount allowed under current Federal law. Participants should consult a tax advisor for specific questions.

Eligible Expenses

Eligible Dependent Care expenses are work-related expenses Incurred for qualifying individuals (see next subsection). Expenses are for the care of a qualifying person only if their main purpose is the person's well-being and protection, and must be Incurred to enable the Participant (and Spouse, if applicable), to be Gainfully Employed. These expenses include:

- Work-related babysitting (i.e., not social) and licensed daycare center costs;
- After-school* day care costs;
- Incidental housekeeping services in the Employee's home included with day care.

*Expenses for care do not include amounts for education. The IRS provides an example of a five year old child who goes to kindergarten in the morning. In the afternoon, the child attends an after-school day care program at the same school. The total cost of sending the child to school is $3,000, of which $1,800 is for the after-school day care program. Only the $1,800 qualifies as non-educational care with the primary purpose of providing for a child's well-being and protection.

NOTE: The provider's name, address, and taxpayer identification are required to be provided on the Employee's tax return. An Employee may not claim an exclusion for reimbursement of Dependent Care expenses unless he or she provides on his or her tax return the name, address and taxpayer identification

number (TIN) of the service provider. (No TIN is necessary for tax-exempt organizations.) If the caregiver is an individual, the TIN is the individual's social security number.

An Employee may claim reimbursement for payments made to a relative; however, he or she may not be reimbursed for payments he or she makes to one of his or her tax-eligible Dependents or any of his or her children age 18 or younger.

Ineligible Expenses

Expenses which are ineligible for reimbursement include, but are not limited to:

- Babysitting for social reasons;
- Expenses Incurred on or after a child's 13th birthday;
- Overnight camp;
- Education, food or clothing expenses that are not incidental to and inseparably part of the care;
- Costs of transportation;
- Tuition for children in the first grade or above and for kindergarten education; and
- Payments made for care provided by someone eligible to be claimed as a Dependent on the Participant's income tax form (although payment to another relative is permissible) or to any of his or her children age 18 or younger.

Qualifying Individuals

Individuals who qualify as Dependents for the purpose of this Plan are:

- Children, grandchildren and siblings who are under the age of 13 and for whom the Participant is entitled to claim an exemption under Code Section 151(c) (*NOTE: A Dependent Care election may be canceled when a Dependent child turns age 13 in the middle of a Plan Year and is no longer a qualifying individual for purposes of the DCAP rules)*; and

- A qualifying individual (i.e. Spouse, Dependent, grandparent, parent) of the Participant who is physically or mentally incapable of caring for himself and meets the income exemption amount required by the IRS.

For purposes of DCAP provisions, including contribution limits, eligible Dependents shall not include an individual legally separated from the Employee under a divorce or separate maintenance decree, nor shall it include an individual who, although married to the Employee, files a separate federal income tax return, maintains a separate principal residence from the Employee during the last six months of the taxable year and does not furnish more than one-half the cost of maintaining the principal place of residence. However, if an Employee is divorced or legally separated, he or she can generally have his or her child's Dependent Care expenses reimbursed if he or she is the custodial parent (i.e., if he or she has custody of the child for a longer period of time during the Plan Year than the other parent). The following exceptions would override the custodial parent rule and permit the Employee, as a non-custodial parent, to have his or her child's Dependent Care expenses eligible for payment from his or her DCAP:

- The custodial parent formally releases claim to the federal income tax Dependent Care exemption for the year; or
- The Employee provides over half the support of the child under a multiple support agreement.

Federal Reporting Requirement

An Employee is required to report on his or her federal income tax return, the name(s) and tax identification number(s) or Social Security number(s) of his or her providers of dependent care services.

NOTE: *The tax identification number is not required if the provider of dependent care services is a tax-exempt organization (i.e., a church-sponsored nursery school or a county daycare center).*

Understanding Qualified Dependent Care Benefit Options with the Flexible Spending Account and the Federal Income Tax Credit

The federal government provides an income tax credit for Dependent Care expenses such as those described earlier. While an Employee may take advantage of the tax benefits available under both the DCAP and the federal income tax credit, he or she cannot use both the tax credit and the spending account for the same Dependent Care expenses, and expenses eligible for the tax credit are reduced, on a dollar-for-dollar basis, by the amount he or she contributes to a DCAP.

The practical effect of contributing dollars to a DCAP which he or she would otherwise receive in his or her salary is that the income which he or she reports for federal, applicable state and FICA taxes is reduced, as may be allowed by applicable law. The amount of this contribution will not be reported on the Employee's W-2 form as part of his or her earnings. There will be no taxes due on this amount.

The amount which an Employee can save in taxes depends on the amount of his or her contribution and his or her taxable income with and without the contribution. He or she can approximate this amount of savings by determining his or her marginal, i.e., top, tax rate. The higher his or her marginal tax rate, the greater amount he or she can save in taxes with this spending account.

In deciding whether to use the DCAP or the federal tax credit, an Employee needs to evaluate which will be more advantageous to him. In most cases, the spending account will provide him the greater tax savings.

Since the spending account advantage may change as revisions are made in the tax rules, an Employee will want to monitor his or her personal situation and may also wish to consult a tax advisor.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Claims Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes that may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for reimbursement, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.

8. To appoint and supervise a Claims Administrator to pay claims.
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Qualified Medical Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Claims under the Health Care and Dependent Care Assistance Program (DCAP)

An Employee may submit claims as they are Incurred before the end of the Plan Year. An Employee may continue to submit claims for up to 30 days following the close of the Plan Year.

Claim forms for covered expenses should be accompanied by:

- A written, dated statement from an independent third party stating the health care and/or Dependent Care expense has been Incurred and the amount of the expense. The following information must be set forth on the claim for reimbursement:
    - Patient's name.
    - Nature of Incurred expense.
    - Amount of requested reimbursement.
    - Date of service.
    - For Dependent Care Assistance Program (DCAP) only, include the provider's name and the provider's tax identification number or social security number.

- A written statement that the health care and/or Dependent Care expense has not been reimbursed under any other health plan coverage any other DCAP (included on claim form).
- For Health Care FSA only, an Employee is required to submit an explanation of benefits (EOB); or, if the expense is totally ineligible for reimbursement, a statement from the provider rather than just a proof of payment, such as a canceled check.

The Plan shall process a claim in accordance with its reasonable claims procedures. The Plan has a right to secure independent medical advice and to require such other evidence as it deems necessary to decide the claim. If the Plan requires more than 30 days to process a claim, the claimant will be notified of the delay, the reason for the delay, and the expected date a decision will be made. If the claim is denied in whole or in part, the Plan shall furnish the Participant a written explanation for the denial as described below.

Claims should be sent to:
ACS Benefit Services LLC
5660 University Parkway Fifth Floor
Winston-Salem, NC 27105
Phone: 1-336-714-1450
Fax: 1-336-759-0404
Website/Email Address: www.acsbenefitservices.com

NOTE: Claim reimbursements will be made directly to the Employee and will be issued on a regular basis.

Claims in Excess of the Employee's Account

If an Employee submits a claim for more than the current balance of his or her applicable Health Care FSA, his or her claim will be paid up to the total he or she elected for the Plan Year minus any prior payments for the Plan Year. However, if a "qualified reservist distribution" (QRD) is requested pursuant to the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act), the amount available will be the amount contributed to the Health Care FSA as of the date of the QRD request minus Health Care FSA reimbursements received as of the date of the QRD request.

If an Employee submits a claim for more than the current balance of his or her applicable DCAP, his or her claim will be paid up to the balance in his or her account, and the remainder of the claim will automatically be paid as additional contributions are made to the account. Claims do not need to be resubmitted.

Appeals

Claims Under the Premium Only Plan, Health Care FSA or DCAP - Explanation of Denial
If a claim is denied in or whole or in part, the Participant will be provided with a notice, either in writing or electronically, containing the following information:

- The specific reason or reasons for the denial.
- The specific Plan provision or provisions on which the denial is based.
- A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
- A statement that the Participant, the Participant or duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine relevant Plan Documents and records upon request at no charge and to submit written comments on issues. The Participant also has the right to obtain applicable determination procedures used to ascertain coverage under a Qualified Medical Child Support Order at no charge from the Plan Administrator.
- A statement that the claim and its denial shall be reviewed upon submission of a written request.
- A statement that failure to submit a written request for review within 180 days after the receipt of the written explanation of the claim denial shall make the Plan's decision final.

Decision on Review
A claim and its denial (in whole or in part) shall be reviewed if a written request for appeal is filed within 180 days after receipt of the written explanation of the claim denial by the Participant. Appeals should be sent to the Claims Administrator, except for Premium Only Plan appeals, which should be sent to the Plan Administrator. Otherwise, the initial decision shall be the final decision of the Plan. The Plan shall review the request for appeal information and comments submitted by the Participant or the Participant's duly authorized representative. The Plan shall furnish the Participant with a written explanation of its decision with respect to the appeal within 60 days following receipt of the written appeal.

The Participant will be provided with a notice of the explanation of the appeal decision, either in writing or electronically, containing the following information:

- The specific reason or reasons for the decision.
- The specific Plan provisions and records, if any, on which the decision is based.
- If applicable, a response to the information and comments submitted by the Participant and his or her duly authorized representative.
- A statement of the Participant's right to review relevant documents and other information (upon request and at no charge).
- If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then 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 the Participant upon request.

Limitation of Action

A Participant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within two years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

A Participant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within two years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

MISCELLANEOUS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of any other applicable law.

Fraud

It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Employee and eligible dependents who are Participants under this Plan.

A determination by the Plan that a rescission is warranted will be considered an adverse benefit determination, as defined by the Affordable Care Act (ACA), for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the ACA and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Word Usage

Whenever any words are used herein in the singular or plural, they shall be construed as though they were in plural or singular, as the case may be, in all cases where they would so apply.

The Effect of the Plan on Other Benefits

Salary dollars contributed by an Employee to his or her Health Care Flexible Spending Account are not subject to federal income taxes or FICA (Social Security) taxes, and will not be included in the taxable income reported on the Employee's W-2 form.

Under present law, an Employee's earnings, for the purpose of determining his or her FICA earnings and his or her eventual Social Security benefits, do not include salary reduction contributions made to the Plan. This means that if an Employee earns less than the Social Security wage base, his or her eventual Social Security benefits will be slightly reduced. The value of the FICA and federal (and state, if applicable) income tax savings to the Employee will normally exceed any reduction in his or her eventual Social Security benefit.

No Guarantee of Tax Consequences

It is the sole obligation of each Participant to determine whether any payment under this Plan is excludable from their gross income for federal, state, or local tax purposes. Although certain tax treatment of Plan benefits is expected and desired, it is not guaranteed that any particular tax consequence result from participation in the Plan or that amounts paid as Plan benefits will be excludable from the Participant's gross income as applicable. Additionally, the Participant must notify the Plan Administrator if he or she has any reason to believe that such payment is not so excludable.

Nondiscrimination

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between similarly situated individuals. The Plan Administrator shall have the authority to adjust contributions to avoid discrimination.

No Waiver or Estoppel

All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

If applicable, whenever payments have been made by this Plan in a total amount, at any time, in excess of the amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.

The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling the Employer at 1-336-849-7900.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her

personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:
Privacy Officer
County of Yadkin
217 E Willow St
Yadkinville, NC 27055
Phone: 1-336-849-7900

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. 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.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

34