THE RESTATED
MASON PUBLIC SCHOOLS
FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

TO OUR EMPLOYEES

This document is called a Summary Plan Description. Its purpose is to explain the provisions of the Restated Mason Public Schools Flexible Benefits Plan.

The Plan was originally effective as of January 1, 1997. It was first amended and restated effective July 1, 2002; and was again amended and restated effective October 1, 2014. The Effective Date of this Restated Plan is October 1, 2022.

You are urged to read this Summary Plan Description carefully. It does not replace the provisions of the Plan documents. The Plan documents govern the operation of the Plan. However, we have tried to make this Summary Plan Description complete and accurate without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan documents, the terms of the Plan documents will prevail.

The existence of this Plan does not grant employees any legal right to continue employment with the Employer or affect the Employer's right to separate employees from employment.

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I. PLAN OVERVIEW

Under the Restated Mason Public Schools Flexible Benefits Plan (the "Plan"), you will have the opportunity on an annual basis to elect to participate in a number of qualified non-taxable Benefits. The cost of the Benefits that you select may be paid by reducing your salary each pay period and contributing the funds derived from that reduction of salary to accounts maintained under the Plan. You may also be allowed to waive participation in the insured major medical coverage sponsored by the Employer and to receive a taxable cash Benefit instead.

II. PARTICIPATION

If you are an Employee of the Mason Public Schools, who is or will be eligible to participate in group health insurance offered by the Employer on October 1, 2022, and you file the appropriate election forms with the Administrator during the Election Period under the Plan, you will become a Participant under the restated Plan on October 1, 2022. If you are not eligible to participate on October 1, 2022, you may become a Participant on the first day of the month following the date you become eligible for coverage under the Employer's group health insurance plan, provided you file appropriate election forms with the Administrator before the date that you are supposed to begin participating.

If you are an Employee who is a member of a bargaining unit with a Collective Bargaining Agreement with the Employer, you will begin to participate at the time mandated by the Collective Bargaining Agreement, provided that you have met all other requirements for participation stated in the Collective Bargaining Agreement, if any.

Going forward, your participation in the Plan will terminate if you separate from service with the Employer, no longer satisfy the eligibility requirements for participation (e.g., you no longer satisfy the conditions for participation in the Employer's group health insurance plan), or the Plan is terminated.

III. BENEFITS THAT YOU MAY SELECT

The "Election Period" shall be the period before the first day of each Plan Year as designated by the Administrator. The first day of each new Plan Year is October 1. If you become eligible to participate in the Plan on a date that is not within the Election Period, you will be permitted to submit election forms during the thirty (30) calendar day period immediately before the date that your participation under the Plan is supposed to begin.

The following paragraphs generally describe the Benefits available to you under the Plan:

Inured Coverages

"Insured Coverages" include group health coverage, dental care coverage, vision care coverage, long-term disability insurance coverage and group term life insurance coverage provided under Policies that may be available to you, your Spouse and eligible Dependents as described in the Collective Bargaining Agreement that covers your employment or, if you are a non-represented Employee, in separate agreements or in the Employer's policies pertaining to Benefits for non-represented Employees, from time to time, all of which are incorporated herein by reference.

Unless you waive insured group medical coverage as described in the section titled "Waiver of Medical Insurance Coverage; Cash Option," you will receive coverage under the Policy or Policies maintained by the Employer to provide group medical coverage as you have designated in the appropriate election form. Coverage will be provided to you in accordance with the pertinent provisions of the Collective Bargaining Agreement between the Employer and the bargaining unit that represents you or, if you are not a member of a bargaining unit, in accordance with the terms of your employment with the Employer.

Insured Coverages; Employee Portion.

The Employer will offer you certain insurance coverages, including under the Employer's insured group medical plan. Under the terms of your employment with the Employer, you may be responsible to contribute a portion of the Premiums for the coverages that you elect. By selecting this Benefit, your compensation each pay period will be reduced under a Salary Reduction Agreement to pay your contribution in the amount which, when added to the Employer's portion, is required for the Premium for the coverages that you designate in your Benefit election form. Funds derived in this manner will be credited to your Insured Coverages Premium Account. Premiums will be paid from your Insured Coverages Premium Account as required by the terms of the Policies. Amounts credited to your Insured Coverages Premium Account may only be used to pay insurance Premiums, and any amount credited to your Account within a Plan Year that is not used for that purpose before the end of that Plan Year will be deemed forfeited.

Waiver of Medical Insurance Coverage; Cash Option

This is a Benefit gives you the option of waiving your participation in the medical insurance coverage offered by the Employer and receiving a cash Benefit in lieu of coverage. This Benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you.

Under the procedures effective for this Benefit as of the date of this Summary Plan Description, you may elect to not receive coverage under the medical insurance plan maintained by the Employer for a Plan Year by merely executing a Waiver form provided by the Administrator within the relevant Election Period and receive cash in lieu of medical insurance coverage in an amount and at the times determined under the provisions of the Collective Bargaining Agreement between the Employer and the bargaining unit that represents you or, if you are not a member of a bargaining unit, under the terms of your employment with the Employer.

Contact the Plan Administrator if you have any question about these procedures.

Health Savings Account Contributions

You may have the option of participating in a Health Savings Account (HSA) Contribution Benefit that allows you to contribute money to your HSA on a pre-tax basis. This Benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you. In order to participate in this Benefit, you must be eligible to participate in, and you must enroll in, an HSA. To be HSA-eligible you must be enrolled in a high deductible health plan sponsored by the Employer, but you may not be covered by any other medical insurance, other than permitted coverage. So, for example, you cannot contribute to an HSA if you are participating in the Medical Reimbursement Plan (described below) on a general basis, even if you are also participating in the high deductible health plan **(although you can participate in the Medical Reimbursement Plan on a limited basis)**. See the Administrator if you have any question regarding your HSA eligibility.

The Employer may (but is not required by the Code) to contribute funds to your HSA. Any such Employer contributions would be in addition to the contributions derived from your election to reduce your salary. Whether the Employer will also contribute funds to your HSA will be determined by the terms of your employment. Note that the sum of the Employer's contributions and your contributions to your HSA may not exceed the maximum allowable contribution under Section 223 of the Code.

Please note that the provisions of the Plan regarding changes to Benefit elections (explained in Section V of this Summary Plan Description) do not apply to salary reductions made for HSA contributions. Consequently, you may revoke or modify a salary reduction agreement to fund an HSA, prospectively, at any time during a Plan Year.

Your HSA is not an Employer-sponsored employee benefit plan. In order to elect the HSA Benefit under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA so that your pre-tax salary reductions can be sent through the Employer's payroll system to your designated HSA trustee/custodian. The Employer does not maintain or administer your HSA. However, the Administrator will maintain records of HSA contributions sent to your HSA trustee/custodian through the Plan.

You should refer to the documents provided to you by your HSA trustee/custodian for information regarding the operation of your HSA, including how medical expenses are paid from your HSA and how those distributions are treated for tax purposes.

The Plan Administrator may establish rules and a procedure for the election of salary reductions by Participant's to fund HSAs that are reasonably and practicably consistent with the provisions of this Plan, and in compliance with applicable laws, regulations, and published guidance.

To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

Medical Reimbursement Plan

You may have the option of participating in a medical reimbursement plan, which is a flexible spending account plan that allows you to pay uninsured medical care expenses using pre-tax dollars. This Benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you. When you elect this Benefit, your compensation will be reduced under a Salary Reduction Agreement that you enter into with the Employer, and money derived from the reduction of your salary will be credited to a Medical Expense Reimbursement Account established on your behalf by the Administrator under the Medical Reimbursement Plan. If you choose to participate in this Benefit, each Plan Year you may set aside up to the maximum amount of Benefit permitted under the Code. The maximum amount is periodically adjusted for inflation by the IRS. The Administrator will tell you what the maximum amount the Benefit is before each Plan Year's Election Period. You must make your election during the Election Period before the first day of the Plan Year for which the election is being made.

Under the so-called "Uniform Coverage Rule," the full amount that you elect for reimbursement of medical care expenses for a Plan Year (reduced by prior reimbursements during the Plan Year) must be available to reimburse eligible medical expenses at all times during the Plan Year, beginning on the first day of the Plan Year (October 1), regardless of the actual amount of salary reduction that has been credited to your Medical Expense Reimbursement Account. No reimbursement, however, will be available to pay medical expenses incurred after your coverage under this Plan has been terminated, unless you elect continuation coverage under COBRA or you are entitled to submit expenses during the Grace Period.

You can be reimbursed for otherwise-eligible medical expenses incurred by a child through December 31 of the calendar year in which the child turns age 26, regardless of the child's residency, employment, financial dependence, student status, marital status, or status as a tax dependent.

Because of Internal Revenue Service rules, it is important that you estimate your annual medical expenses carefully before choosing the amount that you should put into your Medical Expense Reimbursement Account. Under current law, amounts that you put into your Medical Care Reimbursement Account, but that you do not use for the reimbursement of eligible medical expenses by the end of the time period for the filing of claims for the Plan Year (described in Section VII, below), are deemed forfeited and are lost forever.

Examples of expenses that **are** eligible for reimbursement under this Benefit include: deductibles and co-payments under the Employer's medical insurance plan; mental health services in excess of plan benefits; charges in excess of established usual and customary amounts as determined under the Employer's medical insurance plan; uninsured dental services; medical equipment; chiropractic services; prescription drug fees; podiatrist fees; support or corrective devices (such as orthopedic shoes) that are necessary for daily living; acupuncture fees; eye exams, eyeglasses, and contact lenses (not covered by a vision care program); hearing exams and hearing aids; deductibles, co-payments and uninsured expenses under your spouse's health care plan. Generally, these are among the medical expenses authorized under Section 213 of the Internal Revenue Code of 1986, as amended.

In addition, you may receive reimbursement for expenses that you incur for certain over-the-counter drugs (i.e., non-prescription drugs) that you purchase for yourself, your spouse, or your dependents. Over-the-counter drugs that are eligible for reimbursement are those that are for "medical care." An over-the-counter drug is for "medical care" if it is for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. In addition, there has to be an "imminent probability" of disease. Therefore, items that you take only for your general health and well-being are not reimbursable. Cosmetic items (deodorant, face cream, hand lotion, etc.) and toiletries (toothpaste, shaving lotion, mouthwash) are not reimbursable. Typically, drugs like Claritin, Sudafed, or aspirin will almost always satisfy the "medical care" requirement. Items like vitamins or other dietary supplements may be for medical care in some circumstances, but are usually used only for general well-being and, therefore, are not reimbursable. After December 31, 2019, expenses incurred for menstrual care products (as defined in Section 223(d)(2)(D) of the Code) may be treated as incurred for medical care. To be reimbursable, you must present proper substantiation showing the cost of the drug and that the over-the-counter drug is necessary to treat a medical condition.

Examples of expenses that **are not** eligible for reimbursement include: health care premiums; any expense reimbursed by a health or dental plan; cosmetic surgery, unless medically necessary; marriage or family counseling; funeral or burial expenses; household or domestic help, even if advised by your doctor; custodial care; any expenses incurred in connection with an illegal operation or treatment; health club dues; social activities; membership fees; bottled water; maternity clothes, diaper services and related items; cosmetics, toiletries and toothpastes; meals and lodging while away from home for medical treatment for the relief of a specific health condition; medical expenses you itemize or for which you take a tax credit on your federal income tax return.

Limited Purpose Medical Reimbursement Plan

Some Employees of the District may be eligible to participate in a high deductible health plan offered by the Employer and a Health Savings Account program. Under applicable federal laws and regulations, with certain exceptions, participants in high deductible health plans may not participate in any other health plans. One exception to this prohibition is participation in a flexible spending account plan which provides reimbursement for limited types of medical expenses, such as dental and vision care, and/or reimbursement for all types of eligible medical expenses after the minimum deductible under the high deductible health plan has been satisfied.

Consequently, the Employer has included provisions in the Medical Reimbursement Plan that allows Employees who participate in a high deductible health plan and Health Savings Account program to elect to reduce salary for the purpose of paying Eligible Medical Expenses on a limited basis, including dental and vision expenses, and any other expenses permitted under Section 223 of the Code using pre-tax dollars. In addition, after the minimum deductible under the high deductible health plan is satisfied, all Eligible Medical Expenses subsequently incurred may be reimbursed to the extent of the Benefit elected by the Participant.

If you do not participate in a high deductible health plan and a health savings account, you may participate in the general purpose medical expense reimbursement plan that is described in the preceding section. If you choose to participate in this Benefit, you may set aside an amount of

money for each Plan Year to pay for Eligible Medical Expenses on a pre-tax basis, subject to the limits discussed in the preceding section describing the Medical Expense Reimbursement plan.

Dependent Care Assistance Plan

You may have the option of participating in a dependent care assistance plan that allows you to pay certain dependent care expenses using pre-tax dollars. This Benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you. When you select this Benefit, you may set aside pre-tax dollars to pay for qualifying dependent care expenses, which can include, for example, care for your children or your disabled spouse or parent. Your compensation will be reduced under a Salary Reduction Agreement that you enter into with the Employer, in an amount that you chose. Amounts derived from the reduction of your salary will be credited to a Dependent Care Reimbursement Account that the Administrator will establish under the Dependent Care Assistance Plan on your behalf. As you incur eligible dependent care expenses, you can request reimbursement for those expenses with pre-tax dollars from your Dependent Care Reimbursement Account.

If you choose to participate in this Benefit, you may set aside an amount of money for each Plan Year described below. You must make your election during the Election Period before the first day of the Plan Year for which the election is being made.

The reimbursement of eligible dependent care expenses is limited to amounts in your Dependent Care Reimbursement Account. If you submit a claim that exceeds the amount available in your Dependent Care Reimbursement Account, the excess claim will be held in suspense until with have contributed sufficient amounts to your Dependent Care Reimbursement Account via your Salary Reduction Agreement to cover the expense, provided the claim otherwise qualifies for payment of a Benefit. In no event will amounts reimbursed under this Plan exceed the balance in your Dependent Care Reimbursement Account.

Dependent care expenses are eligible for reimbursement if they are necessary to enable you to work (or you and your spouse to work if you are married). If your spouse is not employed, your dependent care expenses will not be eligible for reimbursement under the Plan, unless your spouse is a full-time student or physically or mentally incapable of self-care.

Each year that you participate in this Benefit, you will designate the amount that you want deducted from your salary for that year. Subject to the dollar limitation described in the next paragraph, you may choose to reduce your salary for this purpose up to $5,000 ($2,500 per year if you are married and filing separately). The amount that you choose will be divided and deducted on a pre-tax basis from each of your paychecks throughout the year and credited to your Dependent Care Reimbursement Account.

Your contributions to your Dependent Care Reimbursement Account cannot exceed your annual earned income or that of your spouse, **whichever is less**. If your spouse is a full-time student or incapable of self-support, your spouse's annual income will be considered to be $3,000 ($250 per month) if you have one dependent, or $6,000 ($500 per month) if you have two or more dependents.

Because of Internal Revenue Service rules, it is important that you estimate your annual dependent care expenses carefully before choosing the amount that you should put into your Dependent Care Reimbursement Account. Under current law, amounts that you put into your Dependent Care Reimbursement Account, but that you do not use for the reimbursement of eligible dependent care expenses by the end of the time period for the filing of claims for the Plan Year (described in Section VII, below), are deemed forfeited and are lost forever.

Expenses that are eligible for reimbursement under the Plan are all expenses that you incur for Qualifying Services during a Plan Year and which are paid to a person who is not: (a) an individual with respect to whom a personal exemption is allowable under Section 151(c) of the Code to you or your spouse; (b) your spouse; (c) your child who is under the age of 19 years at the end of the Plan Year in which the expenses were incurred; or, (d) a parent of your child who is under age 13, such as a former spouse who is the child's non-custodial parent.

Qualifying Services are services relating to the care of a Qualifying Individual (described below) that enable you or your spouse to remain gainfully employed which are performed:

(a) in your home; or

(b) outside your home, for (i) the care of your Dependent who is a under the age of 13 years, (ii) the care of any other Dependent who spends at least eight (8) hours per day in your household. In addition, and not by way of limitation, the term Qualifying Services includes expenses incurred for services provided by a Qualifying Day Care Center.

A Qualifying Day Care Center is a day care center which: (a) complies with all applicable laws and regulations of the state and town, city or village in which it is located; (b) provides care for more than six individuals (other than individuals who reside at the day care center); and (c) receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

In the case of divorced or separated parents, a child shall be treated as a Dependent of the custodial parent (within the meaning of Section 152(e) of the Code) and shall not be treated as a Dependent with respect to the noncustodial parent.

A "Dependent" generally is a "Qualifying Individual," which means (a) a tax dependent of the Participant as defined in Section 152 of the Code who is under the age of 13 and who is a qualifying child of the Participant as defined in Section 152(a)(1) of the Code; (b) a tax dependent of the Participant as defined in Section 152 of the Code, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Section 21(e)(5) of the Code, be treated as a qualifying child of the custodial parent (within the meaning of Section 152(e))and shall not be treated as a qualifying child with respect to the noncustodial parent.

Examples of dependent care expenses that **are** eligible for reimbursement include charges from: a licensed and qualifying childcare center; a nursery school; in-home care for dependents unable to care for themselves; daytime summer camp; adult day care center; adult private sitter, nanny or home care companion.

Examples of expenses that **are not** eligible for reimbursement from your Dependent Care Reimbursement Account include: nursing home charges; overnight camp and schooling fees for children in the first grade and up; food and clothing expenses; payments to a spouse or to a person for whom you claim a dependent exemption on your federal income tax return; expenses you deduct or for which you take a tax credit on your federal income tax return.

The Dependent Care Reimbursement Account is just one way that you can attain a tax benefit for qualified dependent care expenses. The Internal Revenue Code also gives you a tax credit for qualified dependent care expenses when you file your income tax return. If your dependent care expenses are eligible for reimbursement from your Dependent Care Reimbursement Account, they also qualify for the federal government's dependent care tax credit. You can use both the Dependent Care Reimbursement Account and the federal tax credit, but you cannot claim the same expenses for both. You may want to consult a tax specialist for advice on whether it would be most advantageous for you to use one or the other, or both of these tax benefits.

IV. REDUCING YOUR PAY TO FUND BENEFITS

You will be given the opportunity to elect Benefits for each Plan Year during the Election Period immediately preceding the Plan Year. The "Election Period" will be a period preceding the first day of each Plan Year, as designated by the Administrator. If you become eligible to participate in the Plan on a date that is not within the Election Period, you will be permitted to make Benefit selections during the thirty (30) calendar day period immediately preceding the date that your participation under the Plan is supposed to begin.

When you complete your Salary Reduction Agreement, you can specify the amount of HSA Contributions that you wish to pay for with your salary reduction (provided that you are HSA-eligible). From then on, you make a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

During the Election Period, you will need to indicate whether you want to participate in one or more of the Employer's Flexible Spending Account Plans. Of course, you can choose not to participate in either of them. If you choose to participate in one or more of those Benefits you must designate the amounts that you want to contribute to each, within the applicable dollar limits.

As an Eligible Employee, you will have the opportunity to select Benefits under the Plan once each year during the Election Period. To continue participating in the Plan, you must complete a Benefit election form during the Election Period. However, if you do not complete a Benefit election form during the Election Period, you will be deemed to have elected to continue coverage under the Benefits and in the same amounts during the ensuing Plan Year that were in effect during the prior Plan Year.

The sum of the amounts that you choose to contribute to the Benefits under the Plan will be the total amount by which your salary must be reduced for the Plan Year in order to fund those Benefits on a **pre-tax basis**. You should complete a Salary Reduction Agreement during the Election Period if you want the Employer to reduce your compensation to provide the Benefits that you have chosen with pre-tax dollars.

The amount of the reduction in your compensation may be changed by the Administrator, in its sole discretion, for the purpose of complying with applicable rules against discrimination, and as permitted under rules described below in Section V. In addition, the Administrator may make reasonable adjustments in reductions to your compensation if you have elected to receive fewer paychecks than the full-year's pay schedule (i.e., you do not receive paychecks during the summer months).

V. CHANGING YOUR ELECTIONS

As a rule, a Benefit election that you make under the Plan may not be revoked after the beginning of the Plan Year for which the election applies. However, you may revoke a Benefit election before the end of the Plan Year for which the election applies in certain circumstances. Absent one of these circumstances, the election you make during an Election Period will stay in force for the entire Plan Year for which it was made. Of course, you can always change your election during a subsequent Election Period. . **Please note that these rules do not apply to elections to make contributions to your HSA, and you may revoke your HSA election and make a new election at any time during the Plan Year.**

Notwithstanding the general rule, you may revoke an election under the Plan during a Plan Year for which the election was made, and prospectively make a new election for the remainder of the Plan Year, **under specific circumstances**. A request for an election change must be made in the form and manner prescribed by the Administrator. The Administrator may request additional information in support of the requested change. The change in your Benefit election, if approved by the Administrator, will be effective for pay periods beginning after the date the change is approved.

The following paragraphs generally describe the specific circumstances under which elections may be changed during a Plan Year:

A. Change in Status. You may revoke an election for **accident and health coverage or group-term life insurance coverage**, if provided under the Plan, and make a new election for the remaining portion of the Plan Year if you (i) have a "change in status;" and (ii) your election change is consistent with the particular change in status.

The following events are "changes in status" that may permit you to make a change in election:

1. Events that change your legal marital status, including marriage, death of a spouse, divorce, legal separation, or annulment.

2. Events that change the number of your dependents, including by reason of birth, adoption, placement for adoption, or death of a dependent.

3. Events that change your employment status or that of your spouse or your dependent, such as a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite.

4. Events that cause your dependent to satisfy or cease to satisfy the requirements for coverage, due to attainment of age, student status, or any similar circumstance, as provided in the Employer's accident and health insurance plan.

5. A change in your place of residence or that of your spouse or your dependent.

Generally, a change of election is consistent with a change in status event only if the election change is on account of and corresponds with the change in status.

With respect to other qualified benefits (i.e., other than accident and health coverage or group-term life insurance), you may make a change of election if the election change is on account of and corresponds with a change in status **that affects eligibility for coverage** under the specific Benefit. In addition, you may make a change in election under a dependent care assistance benefit or adoption assistance benefit (if such Benefits are provided under the Plan) that is on account of and corresponds with a **change in status that affects expenses** under the dependent care assistance benefit or adoption assistance benefit.

If you, or your spouse or a dependent become eligible for continuation coverage (COBRA) under a group health plan of the Employer, you may increase payments under the Plan in order to pay for the continuation coverage.

B. Judgment, Decree, or Order. If you become subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your child or for a foster child that is your dependent, the Plan will change your election under the Plan if doing so is necessary for the required coverage to be provided in compliance with the judgment, decree or order. Further, if you present an order to the Plan Administrator that requires that coverage for a child be provided by your spouse, former spouse, or other individual, and you certify to the Plan Administrator that the required coverage is, in fact, being provided, then you may make an election change to cancel coverage for the child under the Plan.

C. Entitlement to Medicare or Medicaid. You may make a prospective election change to cancel or reduce accident or health Benefits under this Plan, if any, if you, your spouse, or a dependent become eligible for coverage under Medicare or Medicaid. You may make a prospective election to commence or increase accident or health Benefit coverage under the Plan if you or your spouse or a dependent who has been entitled to coverage under Medicare or Medicaid, losses eligibility for coverage.

D. Significant Changes in Cost or Coverage.

1. General. You may prospectively amend or revoke an election under this Plan for changes in cost or coverage as described below. **These provisions do not apply to a**

medical expense reimbursement plan (or on account of a change in cost or coverage under the medical expense reimbursement plan) if such a Benefit is provided under this Plan.

2. Cost Changes.

a. Automatic changes. If the cost of a Benefit to which you contribute through salary reductions, increases (or decreases), the Plan Administrator will, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the amount of your salary reductions for that Benefit. For example, if you pay a portion of the cost of your health insurance through a salary reduction agreement under the Plan, and the premiums for your coverage increase during a Plan Year thereby causing your required contributions to increase, the Plan Administrator may automatically increase the amount of your salary reduction from future pay checks by an amount that corresponds to the increase in your required contribution.

b. Significant Cost Changes. If the cost of a Benefit to which you contribute through salary reduction significantly increases or significantly decreases during a Plan Year, you may make a **corresponding change** in your election under the Plan, such as by commencing participation in the Plan for a Benefit that has decreased in cost or, in the case of an increase in cost, revoking an election for that coverage and instead either receiving on a prospective basis coverage under another Benefit providing similar coverage or dropping coverage if no other Benefit providing similar coverage is available.

c. Application to Dependent Care. If you participate in a dependent care assistance flexible spending account under the Plan, you may change a benefit election for an increase or a decrease in cost **only if the cost change is imposed by a dependent care provider who is not related to you.**

3. Coverage Changes.

a. Significant Curtailment Without Loss of Coverage. If you or your spouse or dependent have a significant curtailment of coverage under a Benefit during a Plan Year, but there was not a loss of coverage (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit under an accident or health plan), you may revoke your election for that coverage and instead elect to receive on a prospective basis coverage under another Benefit providing "similar coverage," if another Benefit providing similar coverage is available under the Plan. Coverage under a Benefit is significantly curtailed only if there is an overall reduction in coverage provided under the Benefit so as to constitute reduced coverage generally. Therefore, for example, the elimination of one of your physicians from a network of providers under an accident or health plan would generally not constitute a significant curtailment.

b. Significant Curtailment with Loss of Coverage. If you or your spouse or dependent have a significant curtailment that results in a loss of coverage, you may revoke your election for that coverage and instead elect to either receive on a prospective basis coverage under another Benefit providing "similar coverage," or drop coverage if no similar Benefit is available under the Plan. For purposes of this Plan, a "loss of coverage" means a complete loss of coverage under the Benefit or other coverage option.

c. Addition or Improvement of a Benefit. If the Plan adds a new Benefit option, or if coverage under an existing Benefit option is significantly improved during a Plan Year, the Plan will permit all Eligible Employees (whether or not they have previously made an election under the Plan or have previously elected the improved Benefit) to revoke their elections under the Plan and instead to make an election on a prospective basis for coverage under the new or improved Benefit option.

4. Change in Coverage Under Another Employer Plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or of another employer) if (i) the other plan permits participants to make an election change that would be permitted under this Plan, or (ii) the Plan Year of the Plan is different than the Plan Year under the other plan.

5. Loss of Coverage Under Other Group Health Coverage. You may make an election on a prospective basis to add coverage under the Plan for yourself, your spouse, or a dependent if you, your spouse, or a dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including (i) a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government (as defined in Section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization; (iii) a State health benefits risk pool; or (iv) a foreign government group health plan.

E. Special Requirements relating to the Family and Medical Leave Act. If you take a leave of absence under the Family and Medical Leave Act (FMLA), you may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA.

F. Special Enrollment Rights. You may revoke an election for accident and health coverage and make a new election that corresponds with the special enrollment rights provided in Section 9801(f) of the Code (HIPAA). For example, the adoption of a child satisfies the conditions for special enrollment under Section 9801(f), which may permit you to enroll in family coverage under the District's health insurance plan. If you pay a portion of your health insurance cost through salary reduction under the Plan, and if enrolling in family coverage upon the adoption of a child results in an increase in the cost of your coverage, then you may increase your salary reduction in order to cover the increased cost.

G. Revocation due to reduction in hours of service. You may revoke an election of coverage under a group health plan if your expected hours of service change from at least 30/week to less than 30/week, even if the change does not result in you ceasing to be eligible under the group health plan. The revocation of the election of coverage must correspond to your enrollment in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

H. Revocation due to enrollment in a Qualified Health Plan. You may revoke an election of coverage under a group health plan if you are eligible to enroll in a Qualified Health Plan through a Marketplace/Exchange, either in a Special Enrollment Period or in the regular Open Enrollment Period in the Marketplace. The revocation of the election of coverage must correspond

to your enrollment in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

I. Procedure for Making New Election. You may make a new election within 30 days of the occurrence of an event described in this section that entitles you to revoke your existing election and make a new election, but only if the new election is made on account of and is consistent with the event. The new election will be effective for the balance of the Plan Year following the change of election unless a subsequent event allows for a further election change. Except as provided for HIPAA special enrollment rights, in the event of birth, adoption, or placement for adoption, all election changes will be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was submitted to the Plan Administrator but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable benefit commences later).

VI. LOSING BENEFITS UNDER THE PLAN

The Plan will provide you with Benefits during each Plan Year that you participate. You participate by electing Benefits and reducing your salary to fund Benefits. Benefits will be provided under the terms of the Plan, and the other plans and insurance policies maintained by the Employer to provide Benefits under the Plan.

Circumstances may arise which will prevent you from receiving benefits or which will cause a cessation of Benefits under the Plan. These include you becoming ineligible to participate in the Plan, for example by reason of employment termination, or a change in employment status that results in you not meeting the requirements for participation. No benefits will be paid to you under the Plan for services rendered after the date that you become ineligible to participate.

VII. BENEFIT CLAIMS PROCEDURES

Insured benefits provided in conjunction with this Plan (such as the Employer's insured medical plan) will have their own claims procedures. You should refer to the policies and related documents for the claims procedures under those insured plans.

The Plan provides a claims procedure that is relevant to the non-insured Benefits offered under the Plan. The Administrator will provide you with the required forms and instructions for submitting claims.

If a claim is denied, totally or partially, the Administrator will provide you with a written denial stating (i) the specific reasons for the denial, (ii) references to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide with an explanation of why it is needed, and (iv) an explanation of the Plan's appeal procedure. The written denial will be sent to you within 60 days after receipt of the claim by the Administrator. The 60 days may be extended for up to another 30 days if special circumstances warrant an extension of time. If the Administrator needs an extension to process the claim, you will be notified in writing before the beginning of the extension period. The notice will

include an explanation of the circumstances requiring the extension of time and the date by which the Administrator expects to render a decision on the claim.

You, your beneficiary (where appropriate), or a duly authorized representative of a claimant may appeal the denial of a claim for Benefits by submitting a written request for a full and fair review to the Administrator. You may examine pertinent documents and submit pertinent issues and comments in writing. You may have a representative (who may be a representative of your bargaining unit if you are covered by a collective bargaining agreement) throughout the appeals process. Your written request for a review must be submitted within 60 days of the written notice of denial of the claim. The full and fair review will be completed and a decision rendered by the Administrator within 60 days after receipt of the written request for review. The time for rendering a decision may be extended by written notice, if warranted by special circumstances, for up to 60 days from the date of the receipt of the written request for review. The Administrator's decision will be in writing and will include specific reasons for the decision, with specific references to the Plan provisions on which the decision is based. The decision of the Administrator will be final and binding. The appeal procedure in the Plan is not intended to limit other remedies that may be available to you under applicable statutes, common law, or equity.

VIII. PAYMENT OF BENEFITS

All benefits payable under the Plan will be paid within a reasonable time after the Administrator approves your claims. Under the Medical Reimbursement Plan, the maximum dollar amount that you elected for reimbursement of Eligible Medical Expenses for a Plan Year will be available from the first day of the Plan Year, regardless of the actual amounts credited your Medical Expense Reimbursement Account as of the time that you submit a valid. Under the Dependent Care Assistance Plan, if the amount of a claim exceeds the balance then available to pay the claim in your Dependent Care Reimbursement Account, the amount that is then available in the Account will be paid, and the excess claim will be held in suspense and paid later, provided that amounts sufficient to pay the excess are credited to your Account for that Plan Year.

Amounts payable under insurance policies maintained by the Employer to provide benefits under the Plan will be paid according to the terms and conditions of the policies as established between the Employer and the Insurer. Amounts paid as your contribution to Premiums due on insurance policies will be paid from the general assets of the Employer.

IX. CONTINUATION COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules generally apply to a Health Flexible Spending Account Plan, such as the Medical Expense Reimbursement Plan (unless the Employer is considered a "small employer").

The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). The following paragraphs are intended to summarize your continuation rights under federal law. If federal law changes, the rights

provided under the then-current applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

When Coverage May Be Continued

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

Type of Event	Covered Employee	Covered Spouse	Dependent
Covered Employee's termination of employment or reduction in hours of employment	√	√	√
Divorce or Legal Separation		√	
Child ceasing to be an eligible dependent			√
Death of the Covered Employee		√	√

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Medical Expense Reimbursement Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year (See Section V of this Summary).

If you do not choose continuation coverage, your coverage under the Medical Expense Reimbursement Plan will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your Spouse) must notify the Plan Administrator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g., divorce decree).

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the Plan Administrator within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost of COBRA Coverage

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the first day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

- if the contribution for your continuation coverage is not paid on time or it is significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of

the required premium, or $50, you will be given 30 days to cure the shortfall);

- if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;

- if you become entitled to Medicare; or

- if the Employer no longer provides group health coverage to any of its employees.

X. AMENDMENT AND TERMINATION OF THE PLAN

The Employer intends to maintain the Plan indefinitely. It may be necessary or desirable at times to amend the Plan, or to terminate the Plan. If you are a member of a collective bargaining unit, the Plan cannot be terminated, or amended in a way that affects your benefit levels or eligibility to participate, unless your bargaining unit consents to the termination or amendment. If, however, it becomes necessary to amend the Plan in order to keep it in technical compliance with applicable sections of the Internal Revenue Code or the Treasury Regulations, the Employer may make those amendments without the consent of your bargaining unit. However, the Employer will provide your bargaining unit with written notice of the amendment at least 30 days before the amendment is to become effective. No amendment or termination of the Plan will prevent the payment of benefits on proper claims incurred before the date of the amendment or termination, provided that you were eligible to participate through the date of the amendment or termination.

XI. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS

1. General. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

2. Participant's Rights.

a. Right to Request Restrictions on Uses and Disclosures of Your PHI. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to restrict uses and disclosures to family members, relatives,

friends, or other persons identified by you who are involved in your health care. However, the Plan is not required to agree to your request.

b. Right to Inspect and Copy Your PHI. You have a right to inspect and obtain a copy of your PHI contained in a "Designated Record Set," for as long as the Plan maintains the PHI. For purposes of the Plan, "Designated Record Set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. If you are denied access to your PHI by the Plan, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

c. Right to Request Amendments to Your PHI. You have the right to request the Plan to amend your PHI or a record about you in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

d. Right to Request an Accounting of Disclosures of Your PHI. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment, or health care operations; (2) to you about your own PHI; (3) prior to the compliance date. If the accounting cannot be provided within 60 days, the Plan is automatically entitled to take an additional 30 days to provide the accounting by giving you a written statement of the reasons for the delay and the date by which the accounting will be provided.

e. Right to Exercise Privacy Rights through Your Legally Authorized Representative. You may exercise your rights through a Legally Authorized Representative. Your Legally Authorized Representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Please note that the Plan at all times retains the discretion to deny a representative's access to your PHI if the Plan believe that giving access could subject you to abuse or neglect. This also applies to representatives of minors.

f. Right to Receive Notice of Privacy Rights. You have the right to be informed of the privacy practices of the Plan, as well as to be informed of your privacy rights with respect to your PHI. In addition to the explanation contained in this Summary Plan Description, the Plan has developed and has or will distribute a notice to you that provides a clear explanation of these rights and practices. The Plan must make its Notice available to you if you request it. In addition, the Plan must provide the notice to you: if you are covered by the Plan, at the time of your enrollment; provide a revised notice to you within 60 days of a material revision to the notice; and, notify you of the availability of and how to obtain the notice at least once every three years.

3. Complaints.

If you believe that your privacy rights have been violated or would like to request any of the information listed above, you may contact the Plan's Privacy Officer at the following address: HIPAA Privacy Officer, Mason Public Schools, 201 W. Ash Street, 2A, Mason, MI 48854.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

XII. OTHER IMPORTANT INFORMATION

A. Plan Name. The Restated Mason Public Schools Flexible Benefits Plan.

B. Name, Address and Telephone Number of the Employer:

Mason Public Schools
Attn: Tracey Wooden, Chief Financial Officer
201 W. Ash Street, 2A
Mason, MI 48854
Ph: (517) 676-6493

C. The Employer's Employer Identification Number: 38-6001646

D. Type of Plan: Welfare Benefit Plan.

E. Name, Address and Telephone Number of the Plan Administrator:

Mason Public Schools
Attn: Tracey Wooden, Chief Financial Officer
201 W. Ash Street, 2A
Mason, MI 48854
Ph: (517) 676-6493

F. Plan Number: 501.

G. Name and Address of Agent for Service of Legal Process:

Mason Public Schools
Attn: Superintendent
201 W. Ash Street, 2A
Mason, MI 48854

H. Plan Year: October 1 to September 30.

I. Effective Date of the Plan: September 1, 1997; Restated effective July 1, 2002; Restated effective October 1, 2014; Restated effective October 1, 2022.

XIII. FURTHER INFORMATION

Copies of the Plan and any ancillary insurance contracts are available at the offices of the Administrator.