FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM, INC.

CAFETERIA PLAN

Plan Document

Effective: January 1, 2024

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PURPOSE OF PLAN; ADOPTION OF THE PLAN DOCUMENT

What is the purpose of the *Plan*?

Franciscan Missionaries of Our Lady Health System, Inc. (the "*Plan Sponsor*") previously adopted a Cafeteria Plan, called the "Franciscan Missionaries of Our Lady Health System, Inc. Cafeteria Plan" (the "*Plan*") effective as of January 1, 2013 for the exclusive benefit of eligible *employees.* The *Plan Sponsor* amended and restated the *Plan* effective as of January 1, 2019 to reflect the intervening *Plan* Amendments and the addition of the HSA feature and the Limited Use FSA. The *Plan Sponsor* amended and restated the *Plan* effective as of January 1, 2021 to reflect the intervening *Plan* Amendments and the removal of the dependent care FSA as of December 31, 2019. The *Plan Sponsor* is amending and restating the *Plan* effective as of January 1, 2024 to reflect the intervening *Plan* Amendments since January 1, 2021. The January 1, 2024 Plan document is as set forth herein and as amended from time to time. The purpose of this *Plan* is to allow eligible *employees* to pay eligible *flexible spending expenses and eligible premium expenses* using pre-tax dollars and accumulate money in a *Health Savings Account.*

The intention of the *Plan Sponsor* is that the *Plan continue to* qualify as a "cafeteria plan" within the meaning of *Code* § 125 and the *Plan* shall be construed in a manner consistent with that Section. The tax implications of this *Plan*, however, are subject to rulings, regulations, and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, the *Plan Sponsor* does not represent or warrant to any *participant* that any particular tax consequence will result from participation in this *Plan*. By participating in this *Plan*, each *participant* understands and agrees that, in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the *Plan*, the recipient of the benefit will be responsible for those amounts, without contribution from the *Plan Sponsor.*

This *Plan* is intended not to discriminate as to eligibility or benefits in favor of the prohibited group(s) under *Code* §§ 105 and 125.

Dual Purpose of the Plan Document

The Plan Document is the legal contract which outlines the terms of the Plan. The Plan Document is being distributed to Participants to explain to Participants how the Plan operates and the benefits which are covered under the Plan. As a result, one document is serving as both the "Plan Document" and the "Summary Plan Description."

Effective date

This amended and restated *Plan Document* is effective as of January 1, 2024, and each amendment is effective as of the date set forth therein (the "*effective date*").

Adoption of the Plan

The *Plan Sponsor*, as the settlor of the *Plan*, hereby adopts this *Plan Document* as the written description of the *Plan*. This *Plan Document* amends and replaces any prior statement of the benefits contained in the *Plan* or any predecessor to the *Plan*.

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

Franciscan Missionaries of Our Lady Health System, Inc.

By: Michael E. Gleason
Michael E. Gleason (Dec 20, 2023 07:35 CST)

Michael E. Gleason
Chief Financial Officer

Date: Dec 20, 2023

GENERAL PLAN INFORMATION

***Name of Plan*:**	**Franciscan Missionaries of Our Lady Health System, Inc. Cafeteria Plan**
***Plan Sponsor*:**	**Franciscan Missionaries of Our Lady Health System, Inc. 4200 Essen Lane Baton Rouge, LA 70809 (225) 765-6827**
***Plan Administrator*: (Named Fiduciary)**	**Franciscan Missionaries of Our Lady Health System, Inc. 4200 Essen Lane Baton Rouge, LA 70809 (225) 765-6827**
***Plan Sponsor ID No.* (EIN):**	**72-1028323**
***Plan Year*:**	**January 1 through December 31**
Plan Type:	**Cafeteria Plan Premium Expense Account, Flexible Spending Accounts (Medical and Limited use) and HSA under *Code* §§ 106, 125, and 223**
***Third party administrator*:**	**Voya Financial P.O. Box 929 Manchester, NH 03105**
***Participating employer*(s):**	**Franciscan Missionaries of Our Lady, North American Province, Inc. Franciscan Missionaries of Our Lady Health System, Inc. Franciscan Missionaries of Our Lady University**
Agent for Service of Process:	**Franciscan Missionaries of Our Lady Health System, Inc. 4200 Essen Lane Baton Rouge, LA 70809 (225) 765-6827**

DEFINITIONS

In this section, you will find the definitions for the italicized words found throughout this *Plan Document*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this *Plan Document* for that information.

"***Actively at work***" **or** "***active employment***" means performance by the *employee* of all the regular duties of his occupation at an established business location of a P*articipating Employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor.

"***Alternate recipient***" means any child of a *participant* who is recognized under a *medical child support order* as having a right to benefits under this *Plan* as a *participant's dependent*. For purposes of the benefits provided under this *Plan*, an *alternate recipient* shall be treated as a *dependent*, but for purposes of reporting and disclosure requirements under *ERISA*, an *alternate recipient* shall have the same status as a *participant*.

"***Benefit plan***" means the medical, dental, and vision, benefits provided under a group health plan established and maintained by the *Plan Sponsor* or any successor thereto.

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

"***Cosmetic surgery***" means any procedure that is directed at improving the person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

"***Debit card***" means a banking card enhanced with ATM (automated teller machine) and POS (point-of-sale) features, issued by the *Plan Sponsor* to a *participant* that can be used to pay for *qualified medical flexible spending expenses* and *limited use FSA* expenses electronically.

"***Dependent***" for the Flexible Spending Account Plans means any of the following individuals

(1) A Spouse.

(2) An Employee's "Child" will be an eligible Dependent until the last day of the month in which he reaches the limiting age of twenty-six (26). For this purpose, the term "Child" includes a natural child, stepchild, adopted child, a child placed with the Employee for adoption, foster children and a child for whom the Participant is required to provide coverage due to a medical child support order that the Plan Administrator determines is a "qualified medical child support order." An Employee's Child will be an eligible Dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency or residency status with the Employee or any other person or the death of the biological parent (in the case of an Employee's stepchild who qualifies as a Child).

(3) Any unmarried child age twenty-six (26) or over who is incapable of self-support because of a Handicap (as defined in paragraph (5) below) provided (i) the child is dependent upon the Participant for principal support and maintenance and (ii) the Participant is entitled to an exemption for federal income tax purposes for the child and (iii) the child was covered under the Plan before the end of the month in which he reached age 26. Proof of the continued existence of such incapacity may be requested by the Plan Administrator from time to time.

(4) A Participant's grandchild will be considered a "child" and will be able to have coverage until the last day of the month in which he reaches the limiting age of twenty-six (26) if the child does not qualify under paragraph (2) above and (a) the Participant has court appointed legal custody or joint legal custody of the grandchild as evidenced by a court order by a court of competent jurisdiction and (b) the Participant, in the Employer's sole discretion, has court appointed responsibilities of medical expenses, or is entitled to an exemption on his federal income tax return..

(5) For purposes of this definition, "Handicap" means Mental Retardation or any congenital or acquired physical or mental defect or characteristic preventing or restricting an unmarried child of a covered Employee or Retiree from participating in normal life, or limiting and/or preventing the individual's capacity

to work. Such child's Handicap must be certified by a Physician and approved by the Plan Administrator within 30 days after the date the child would otherwise lose Dependent status.

"***Dependent***" for all plans covered under the *Premium Expense Account* will be defined by the specific provisions of that plan document, insurance certificate or insurance policy.

"***Employee***" means a person who is an Employee of a Participating Employer, regularly scheduled to work for the Participating Employer in an employer-employee relationship; provided, however, that the term "Employee" does not include any individual who is employed by Pinnacle Care Holdings, LLC regardless of whether such individual is later found to be a common law employee or a leased employee of a Participating Employer or "leased employee" (within the meaning of section 414(n) of the Code) of a Participating Employer hereunder. The term "Employee" also does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than two percent (2%) shareholder in an S Corporation. Please refer to the section "Eligibility for Participation" for information concerning which employees are eligible to participate in the Plan.

"***ERISA***" means the Employee Retirement Income Security Act of 1974, as amended.

"***EXHIBIT A***" means the attached list of clinical employee positions (called "Grandfathered **FPTNB Positions**") who have the ability to elect between receiving an Hourly Pay Differential, or, continuing to participate in all Employer benefit plans for which they are otherwise eligible. Any Employee working in the clinical positions listed in Exhibit A who elects to receive the Hourly Pay Differential shall be a FPTNB Employee for the Plan Year and a Class B participant in this Plan for the Plan Year. Exhibit A may be modified from time to time without the need for a formal Plan amendment, but such list shall not be modified in the middle of a Plan Year. Effective January 1, 2022, all FPTNB positions designated on Exhibit A are grandfathered for a current employee working in the FPTNB position only while the current employee elects to remain continuously employed in a FPTNB status. If an employee who is currently working in a FPTNB position elects not to continue in a FPTNB status as of January 1, 2022 or a future date, the position will cease to be a FPTNB position for that employee and all other employees.

"EXHIBIT B" means the list of clinical employee positions (called "Open FTNB Positions") who have the ability, on an annual basis, to elect between receiving an Hourly Pay Differential, or, continuing to participate in all Employer benefit plans for which they are otherwise eligible. Any Employee working in the clinical positions noted on Exhibit B who elects to receive the Hourly Pay Differential shall be a FTNB Employee for the Plan Year and a Class B participant in this Plan for the Plan Year. Exhibit B may be modified from time to time without the need for a formal Plan amendment, but such list shall not be modified in the middle of a Plan Year.

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

"***FMLA leave***" means a leave of absence which a *Participating Employer* is required to extend an *employee* under the provisions of *FMLA*.

"***FPTNB/FTNB Positions***" means the clinical employee positions noted on Exhibit A and Exhibit B.

Effective January 1, 2024, there are two categories of FPTNB/FTNB positions:

(a)"Grandfathered". FPTNB positions are "grandfathered" meaning that no additional positions will be designated as FPTNB positions and each existing FPTNB position will remain a "FPTNB" only if the current Employee elects to continue in the position as a FPTNB employee for the 2024 Plan year. This "grandfathered" class contains both full-

time and part-time positions. If a current Employee does not elect to be a FPTNB employee while working the grandfathered FPTNB position for 2024, the position shall cease to be a FPTNB position for 2024 and future years.

(b) "Open". FTNB positions are "open" meaning that the positions will remain as FTNB positions during each benefit year regardless of whether the employee in the position elects FTNB status.

"FPTNB/FTNB Employee" is a (i) Full-Time Active Employee (.8 FTE or higher) (ii) working in a clinical position identified on the attached Exhibit A or Exhibit B who has completed a written election to receive an Hourly Pay Differential in lieu of participating in the FMOLHS Health Plan for the Plan Year. An Employee working in a FPTNB/ FTNB position who wishes to continue to receive an Hourly Pay Differential in lieu of participating in the FMOLHS Health Plan for the subsequent Plan Year must timely complete and return a written election during the open enrollment period. A FPTNB/FTNB Employee can increase or decrease his hours between 0.50-1.0 FTE in the FPTNB/ FTNB position during a Plan Year but cannot otherwise transfer to a different position during a Plan Year. Note that a FPTNB Employee can include a Part-Time Active Employee.

Unless a *FPTNB/FTNB Employee* incurs a Special Enrollment Period under Code Section 9801(f), such *FPTNB/FTNB Employee* shall be ineligible to participate in the FMOLHS Health Plan for such Plan Year. Each *FPTNB/ FTNB Employee* shall be treated as a Class B Participant. If a *FPTNB/FTNB Employee* incurs a Special Enrollment Period and elects coverage under the FMOLHS Health Plan in the middle of the year, then such *FPTNB/FTNB Employee* shall cease to be a *FPTNB/FTNB Employee* and shall thereafter be treated as a Class A Participant under both the FMOLHS Health Plan and this Plan, as of the date such coverage takes effect.

"***Grace period***" means the period ending with the 15th day of the third month following the end of a *Plan Year* in which the *flexible spending accounts may reimburse expenses*, subject to any unpaid balance in the applicable *accounts*.

"***Health care expense***" means an expense *incurred* for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. A *health care expense* is not one that is merely beneficial to the general health of an individual.

"***Health Savings Account" or "HSA***" means the individual account established under Code Section 223 by a Class A Participant with a vendor that has contracted with the Plan Sponsor to receive pre-tax salary reduction contributions and Non-Elective Employer Contributions.

"***HSA-Eligible Individual***" means an Employee who (a) is eligible to contribute to an HSA under Code Section 223, (b) has elected qualifying high-deductible health plan coverage offered by the Plan Sponsor, and (c) has not elected disqualifying health plan coverage. The *qualified medical flexible spending account* offered hereunder is disqualifying health plan coverage. Class A Participants may not contribute to an HSA through the Plan if they are currently enrolled in the *qualified medical flexible spending account*.

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

"***Hourly Pay Differential***" means the increased hourly base pay provided to a *FPTNB Employee* as set forth on Exhibit A or on the FPTNB Agreement/Enrollment Form.

"***Incurred***" means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are *incurred* for the various steps or

phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *qualified medical flexible spending expenses* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

"***Limited Use Flexible Spending Account" or "Limited Use FSA***" means the account established by the Plan Administrator on behalf of certain Class A Participants through which a participant may elect to reduce his or her salary in order to pay eligible dental and vision expenses but not other *qualified medical flexible spending expenses*. A *Limited Use FSA* is available only to Class A Participants who are enrolled in the high deductible health plan and an HSA.

"***Medical child support order***" **or** "***MCSO***" means any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a *participant's* child or directs a *participant* to provide coverage under a health benefit plan pursuant to a state domestic relations law (including community property law); or
- Enforces a law relating to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health plan.

"***National medical support notice***" **or** "***NMSN***" means a notice that contains the following information:

- The name of an issuing state agency;
- The name and mailing address (if any) of an *employee* who is a *participant* in the *Plan*;
- The name and mailing address of one or more *alternate recipients* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipient(s)*; and
- The identity of an underlying child support order.

"***Non-Elective Employer Contribution***" means an annual amount contributed by a Participating Employer for deposit into the HSAs of Class A Participants who are enrolled in the HSA option, provided that the Participant is deemed to be an *HSA-Eligible Individual*. The *Non-Elective Employer Contribution* is intended to qualify as a non-taxable Employer contribution to an HSA under Code Section 223. The annual limit on contributions to an HSA shall apply to all contributions made by both the *Participating Employer* and the Employee.

"***Open enrollment period***" means the period designated by the Plan Sponsor during November each year when eligible *employees* may enroll for participation and make elections under the *Plan* for the following *Plan Year.*

"***Participant***" means an eligible Employee who is participating in the Plan. The Plan shall have two categories of Plan Participants: A Class A Plan Participant is an eligible Employee who is not a FPTNB Employee or a *FTNB Employee*. A Class B Plan Participant will be limited to a *FPTNB Employee* or a *FTNB Employee*. A reference to a Plan Participant shall include a Class A Plan Participant and a Class B Plan Participant, except where specifically noted otherwise.

"***Participating employer(s)***" means the entities listed in the "General Plan Information" Section.

"***Plan/Plan Document***" means the Franciscan Missionaries of Our Lady Health System, Inc. Cafeteria Plan.

"***Plan Administrator***" means Franciscan Missionaries of Our Lady Health System, Inc.

"***Plan Sponsor***" or "***Employer***" means Franciscan Missionaries of Our Lady Health System, Inc.

"***Plan Year***" means the period from January 1 through December 31 each year.

"***Premium Expense Account***" means an account that allows eligible employees to use tax-free dollars to pay for certain premium expenses under various health insurance programs offered by the Plan Sponsor.

"***Privacy standards***" means the final rule implementing HIPAA's Standards for Privacy of Individually Identifiable Health Information, as amended.

"***Qualified beneficiary***" means:

- An individual who, on the day before a *qualifying event*, is a *spouse* or *dependent* child receiving benefits under the *plan;* or
- In the case of a *qualifying event* resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such *qualifying event*, is a *participant*.

A newborn child of, an adopted child of, or a child placed for adoption with, a *qualified beneficiary* (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the *qualified beneficiary*; however, such child shall not become a *qualified beneficiary*.

A newborn child or child placed for adoption with a *qualified beneficiary* (as defined in the second bullet above) shall become a *qualified beneficiary* in his own right and shall be entitled to benefits as a *qualified beneficiary*.

A qualified beneficiary must notify the Plan Administrator within 30 calendar days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage. The 30 day period begins on the date of the birth, adoption or placement for adoption.

"***Qualified medical child support order***" **or** "***QMCSO***" means a *medical child support order* that creates or recognizes the existence of an *alternate recipient*'s right to, or assigns to an *alternate recipient* the right to, receive health benefits for which a *participant* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *qualified medical child support order*, it must clearly specify the following:

- The name and last known mailing address (if any) of a *participant* and the name and mailing address of each such *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

In addition, a *national medical support notice* shall be deemed a *qualified medical child support order* if it:

- Contains the information set forth above in the definition of *national medical support notice*;
- Identifies either the specific type of coverage or all available group health coverage. If the *Participating employer* receives a *national medical support notice* that does not designate either specific types of coverage or all available coverage, the *participating employer* and the *Plan Administrator* will assume that all are designated;
- Informs the *Plan Administrator* that, if a group health plan has multiple options and a p*articipant* is not enrolled, the issuing agency will make a selection after the *national medical support notice* is qualified; and

- Specifies that the period of coverage may end for the *alternate recipient*(s) only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan* or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to a *participant* and eligible *dependents*, except to the extent necessary to meet the requirements of a state law relating to *medical child support orders*, as described in Social Security Act § 1908 (as added by the Omnibus Budget Reconciliation Act of 1993 § 13822).

"***Qualified medical flexible spending account***" means the account established by the *Plan Administrator* on behalf of the *participant* through which the *participant* may elect to reduce his salary in order to pay *qualified medical flexible spending expenses.*

"***Qualified medical flexible spending expenses or "Qualified Medical FSA***" means a *health care expense* which is excludable as income according to *Code* § 105(b). *Qualified medical flexible spending expenses* are not otherwise reimbursable under the *benefit plan* or other plan or by any other entity and may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

"***Qualifying event***" means any of the following with respect to participation in the *Plan*:

- The termination of coverage due to the death of a *participant*;
- The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a *participant*;
- The divorce or legal separation of a *participant* from his *spouse*;
- A *participant's* entitlement to Medicare coverage; or
- A *dependent* child ceasing to be a *dependent* child.

"***Salary contribution agreement***" means the online or written agreement by a *participant* to reduce his salary or wage in order to fund a *premium expense account* a *qualified medical flexible spending account or a limited use FSA.*

"***Security standards***" mean the final rule implementing *HIPAA's* Security Standards for the Protection of *Electronic PHI,* as amended.

"***Special Enrollment Period***" means the period of time during which an FPTNB Employee or a FTNB Employee can elect out of an existing FPTNB Election or a FTNB Election and begin to participate in all Employer benefit plans for which such FPTNB Employee is otherwise eligible. In the absence of a Special Enrollment Period, a FPTNB Election or a FTNB Election is binding for an entire Plan Year, or in the case of a new hire making a FTNB Election, the remaining portion of the Plan Year. A Special Enrollment Period shall arise in accordance with the provisions of Code Section 9801(f).

"***Spouse***" means a person who is married to a Participant as a result of a legal ceremony which is recognized by the State of Louisiana. For purposes of this Plan, a "Spouse" will not result from a common law marriage.

"***Student***" means an individual who, during each of five calendar months during a taxable year, is a full-time student at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of *student*s in attendance at the place where its educational activities are regularly carried on.

"***Summary health information***" means 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.

"***Plan Document***" means this Plan Document.

"***Third party administrator***" for the FSA Plans means **Voya Financial** for all plans covered under the p*remium expense account* can be found in that specific Plan Document, insurance certificate, or Insurance policy.

"***Uniformed services***" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

"***USERRA***" means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

"***Waiting period***" means an interval of time during which the eligible E*mployee* is in the continuous, *active employment* of his *Participating Employer* before he becomes eligible to participate in the *Plan*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

You are eligible to participate in the *Plan* from the first day of the month following 30 days of employment in a Benefit Eligible Position , which means you are an individual employed by a Participating employer in an exempt or nonexempt employee category that is a .5 FTE or higher.

If you are absent from work due to illness or a medical condition, you will be considered to be *actively at work* during that time period for the purposes of eligibility under this *Plan*.

Special Rules:

1. Special Temporary Rules. The Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the National Emergency or by such other date announced by the Agencies in a future government notification, for all Plan participants, beneficiaries, qualified beneficiaries or claimants wherever located in determining the following periods and dates:

(a) The 30-day period (or 60-day period, if applicable) to request special enrollment under IRC Section 9801(f); and

(b) The date within which claimants may file a benefit claim, appeal of an adverse benefit claim, request an external review (as applicable), or file information to perfect a request for external review upon a finding that the request was not complete.

2. If the Plan Sponsor acquires the stock or assets of an unrelated company which results in employees of the acquired entity being employed by the Plan Sponsor or a Participating employer in Benefit Eligible Positions, and if the Plan is not amended to provide special rules for employees in the acquired entity, the following special accelerated enrollment rules apply if such action does not cause the Plan to discriminate in favor of highly compensated individuals or highly compensated participants as to eligibility to participate or benefits provided under the Plan, in accordance with the requirements of IRC Sections 105(h) and 125, as applicable. In either situation, the Plan Sponsor reserves the right to determine the enrollment period and the enrollment requirements (which includes uploading dependent verification documents in Oracle Employee Self Service under Benefits/My Documents).

(a) The Benefit Eligible Position employees who are not highly compensated individuals under IRC Section 105(h) or highly compensated participants under IRC Section 125 will be eligible to enroll in the Plan during the month in which the acquisition occurs and coverage will be effective as of the first day of the month following the month containing the acquisition date.

(b) If no COBRA rights are available to the Benefit Eligible Position employees who are not highly compensated individuals under IRC Section 105(h) or highly compensated participants under IRC Section 125, the Benefit Eligible Position employees will be eligible to enroll in the Plan prior to the date the acquisition occurs and coverage will be effective on the acquisition date.

When will my participation begin?

New hires: If you are a new *employee*, you are eligible to participate in the Plan on the first day of the month following 30 days of employment. In order to participate in the Plan on the first day of the month following 30 days of employment, you must complete either a *salary contribution agreement (*if you are a Class A Participant) or a

FPTNB or FTNB Agreement/Enrollment Form (if you are a Class B Participant) within 30 days from your original employment date. By completing the *salary contribution agreement* or FPTNB or FTNB Agreement/Enrollment Form, you will be enrolling in this *Plan.*

If you do not submit either the *salary contribution agreement* or the FPTNB or FTNB Agreement/Enrollment Form to the *Plan Administrator* within 30 days of becoming eligible (which is your date of hire for a new employee and the date you become eligible if an existing employee has a change in status), it will be assumed that you have decided not to participate in the *Plan*, and you will not have the opportunity to enroll until the next *open enrollment period.*

Open Enrollment Period: If you are enrolling during an *open enrollment period*, your entry date will be January 1 following the *open enrollment period,* provided that you completed either a *salary contribution agreement* (if you are a Class A Participant) or a FPTNB or FTNB Agreement/Enrollment Form (if you are a Class B Participant) during the *open enrollment period.* If you are a Class B Participant and are working in a FPTNB/FTNB Position for the Plan Year but failed to complete a FPTNB or FTNB Agreement/Enrollment Form during the *open enrollment period*, you will be treated as not having elected FPTNB/FTNB Employee status for the following Plan Year.

Rules for Class A and Class B Participant:

If you are a Class A Participant:

- *y*ou may elect to contribute on a pre-tax basis, to a *flexible spending account (qualified medical or limited use), an HSA or make premium payments*. Eligible *employees* who do not participate in this *Plan* as a Class A Participant may not pay premiums, contribute to an HSA, or contribute on a pre-tax basis, to a *flexible spending account (qualified medical-or limited use).*

- unless you experience a change in circumstances, as described below, your *salary contribution agreement* will continue in force for that *Plan Year,* and you will be required to complete a new *salary contribution agreement* for each subsequent *Plan Year* for which you decide to participate in this *Plan*.

If you are a Class B Participant:

- *y*ou elected to receive the *Hourly Pay Differential* in lieu of any other benefits in this Plan. You may not elect to contribute to the Plan's *flexible spending accounts (qualified medical or limited use), an HSA or make premium payments*. Your participation in this Plan is limited to receiving the Hourly Pay Differential.

- unless you experience a change in circumstances which entitles you to a Special Enrollment Period, as described below, your FPTNB or FTNB Agreement/Enrollment Form will continue in force for the duration of the Plan Year. In addition, if you are a Class B Participant and are working in a FPTNB/FTNB Position for the Plan Year but failed to complete a FPTNB or FTNB Agreement/Enrollment Form during the *annual enrollment period*, you will be treated as NOT having elected FPTNB/FTNB Employee status for the following Plan Year.

May I make mid-year changes in my *Plan* elections?

Generally, except for HSA elections, you cannot change your election to participate in the *Plan* or decrease or increase the amount you have elected to contribute to your account(s) once the *Plan Year* begins. However, certain mid-year changes may be permitted by the Plan Administrator depending on whether you are a Class A Participant or a Class B Participant.

If you are a Class A Participant, you may make a mid-year election change if you experience a change in status event listed below, if that change in status event affects the eligibility for benefits of you, your *spouse*, or your *dependent*, and the election change you make is consistent with the change in status event. Change in status events include:

- Marriage.
- Divorce.
- Birth, adoption, or placement for adoption of a child.
- Death of a *spouse* or *dependent*.
- Termination or commencement of employment by you, your *spouse*, or your *dependent,* which results in a change in eligibility.
- Reduction or increase in hours of employment by you, your *spouse*, or your *dependent* which results in a change in eligibility under the *Plan.*
- Place of residence change by you, your *spouse*, or your *dependent*, which results in a change in eligibility.
- Your *dependent* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance that would make the *dependent* ineligible under *Code* § 152.
- Commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent*.
- A change in worksite of you, your *spouse*, or your *dependent,* which results in a change in eligibility.
- The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by you, your *spouse*, or your *dependent*.

If you are a Class A Participant and experience such a change in status and wish to change your level of coverage, you must submit written notification to the *Plan Administrator* within 30 days of your change in status, as well as a new *salary contribution agreemen*t reflecting your new contribution elections. The *Plan Administrator* reserves the right to require you to submit proof of any change in status at your expense. The change in coverage generally becomes effective on the first day of the month after the date of the change in status provided written notification is timely received and accepted by the *Plan Administrator*, and except that coverage for birth, adoption, or placement for adoption becomes retroactively effective as of the date of the event. Any such change will remain in effect for the remainder of the *Plan Year*.

If you are a Class B Participant, your ability to make a mid- year change is more limited. A Class B Participant is able to make a mid-year change only if you experience an event which entitles you to a Special Enrollment Period under Code Section 9801(f). Such events are generally summarized below:

- You, your Spouse or Dependent lose eligibility for other health coverage because;

  (i) COBRA continuation coverage has been exhausted, or

  (ii) Employer contributions toward such other health coverage stopped or

  (iii) The other health coverage was terminated as a result of loss of eligibility. Loss of eligibility for coverage may result from legal separation, divorce, death, termination of employment or reduction in hours

- You acquire a new Spouse or Dependent by marriage, birth, adoption or placement for adoption.

- You, your Spouse or Dependent become eligible or lose eligibility for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), as required under the Children's Health Insurance Program Reauthorization Act (CHIPRA).

If you are a Class B Participant and are entitled to a Special Enrollment Period and wish to change from a Class B Participant to a Class A Participant, you must submit written notification to the *Plan Administrator* within 30 days of the event entitling you to a Special Enrollment Period (or 60 days in the case of eligibility for or loss of eligibility for Medicaid or CHIP), as well as a new *salary contribution agreemen*t reflecting your new contribution elections. The *Plan Administrator* reserves the right to require you to submit proof of any change at your expense. If the change in coverage is effective: (i) you will cease to be a Class B Participant, (ii) your FPTNB or FTNB Agreement/Enrollment Form will become null and void and (iii) you will become a Class A Participant. The change in coverage generally becomes effective with the first day of the month after the date of the change in status provided written notification is timely received and accepted by the *Plan Administrator*, except that coverage for birth, adoption, or placement for adoption becomes retroactively effective as of the date of the event to the extent required by law. In the event coverage is retroactive, you will be required to refund the Hourly Pay Differential to the extent allowed by law. Any such change will remain in effect for the remainder of the *Plan Year*.

Must a mid-year election change be consistent with the change in circumstances?
Yes, For example, if you are a Class A Participant, you will be permitted to change an election during the *Plan Year* and make a new election for the remainder of the *Plan Year* only if you have a "change in status" and the change you make is consistent with the event. For example, you can only change your election to contribute to the *Premium Expense Account if:*

- The change in status results in you or your spouse or dependent child, gaining or losing eligibility for health coverage under the *benefit plan* or another health plan of your spouse's or dependent child's employer; and
- The election change corresponds with that gain or loss of coverage.

If you are a Class B Participant, you will be permitted to stop your FPTNB or FTNB Election in the middle of the Plan Year only to the extent you have a Special Enrollment Period under Code Section 9801(f).

May I continue participation during *FMLA leave*?
If you are a Class A Participant, and if your leave of absence is qualified under *FMLA* you have the option to terminate your participation or continue your participation in the *Plan* and make payments in a manner determined by the *Plan Administrator*, in its sole discretion, from among the following options:

- Pre-Payment: You may prepay the contributions that will become due during your *FMLA leave*. Under this option, you may make contributions on a pre-tax basis from any available compensation.
- Pay-As-You-Go: You may pay the contributions that become due during your *FMLA leave* on the same schedule as they would otherwise be taken from your pay, on the schedule for continuation of coverage payments under the *Participating Employer's* existing rules for payment, or on any other schedule agreed upon by you and the *Plan Administrator*.
- Catch-Up: The *Plan Sponsor* may advance the contributions on your behalf, and may recoup the contributions upon your return from *FMLA leave*.

The Pre-Payment and the Catch-Up option may not be offered without also offering the Pay-As-You-Go option.

FMLA leave is treated as a change in status. Therefore, when beginning and/or returning from a qualified leave, you must complete a change in status form.

May I continue participation while I am absent under *USERRA*?
If you are a Class A Participant and are absent from employment because you are in the *uniformed service*, you may elect to continue your coverage under this *Plan* for up to 24 months. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions in accordance with the options outlined above for a *participant* who goes on *FMLA leave*. The USERRA continuation period will run concurrently with any other Continuation Coverage period.

When does my participation end?
If you terminate employment with a *Participating employer*, your participation in this *Plan* will terminate on the last day of the pay period you are *actively at work* unless you

- are receiving severance benefits under the Plan Sponsor's System-wide Severance Policy, or
- are a Class A Participant and elect to continue your participation in accordance with the guidelines provided in the "Continuation of Coverage" section.

If you are a Class A Participant, once you terminate your Plan participation, any *qualified medical flexible spending expenses or limited use FSA expenses incurred* during the *Plan Year* prior to the date of termination will be reimbursed by the *Plan* in accordance with the guidelines in the section, "Benefits." Your participation in this *Plan* will also terminate if the P*articipating employer* decides to terminate its participation in this *Plan*, or if you voluntarily decide not to participate under the terms of this *Plan*.

If you are a Class A Participant and if your participation in this *Plan* terminates because you are no longer eligible to participate, you may either revoke your election to participate and terminate your participation in the *Plan* for the remainder of the *Plan Year* or continue your participation in accordance with the "Continuation of Coverage" section. If you do not make payments as required under continuation of coverage, it will be assumed that you elected to revoke your participation in this *Plan*.

If your employment terminates, and you return to eligible employment with your P*articipating employer*, you may rejoin the *Plan* and make a new election for the remainder of the *Plan Year,* as long as the termination was not for the purpose of altering the original election. Your ability to rejoin the Plan as a Class B Participant in the Plan Year containing your original termination will be permitted only if allowed under the tax laws.

If you do not complete and file either a *salary contribution agreement* or a FPTNB or FTNB Agreement/Enrollment Form during the open *enrollment period*, your participation will end at the end of the *Plan Year*. If you had previously completed a FTNB Agreement/Enrollment Form and did not return a FPTNB or FTNB Agreement/Enrollment Form during the open *enrollment period*, you will be treated as not having elected FPTNB/FTNB status for the next Plan Year.

What Happens if I am Terminated and I Receive Severance Benefits under the System-wide Severance Policy? If you are terminated because of a corporate reorganization resulting in a reduction in force and you qualify and receive severance benefits in accordance with the System-wide Severance Policy, your Plan participation will continue for the severance period set forth in the Policy. Your coverage will be that which was in force on the last day worked as an active employee. Once the severance period ends, you may elect to continue your coverage in accordance with the guidelines provided in the "Continuation Coverage" Section. The post termination coverage under the Severance Policy will run simultaneously with your COBRA continuation coverage and will not operate to extend your COBRA coverage period.

What Happens if I am Rehired? A terminated Employee is rehired within 30 calendar days, the Plan Administrator reserves the right to continue the prior benefit elections. If an individual who elected FPTNB/ FTNB status for the Plan Year is rehired within 30 calendar days, his FPTNB/FTNB election will continue and he will not be permitted to make new benefit elections. See the Plan Administrator for application of these rules to your situation.

CONTINUATION COVERAGE

What is Continuation of Coverage?

Continuation coverage provides employees and certain family members the opportunity to continue coverage under the medical flexible spending account or limited use FSA (to the extent allowed by law) within the Franciscan Missionaries of Our Lady Health System, Inc. *Cafeteria Plan* in certain instances where coverage would otherwise end.

If you are a Class A Participant, Continuation coverage for your medical flexible spending account or limited use FSA is available through the end of the current Plan Year only if an unused amount is available in your account and if your coverage or a covered dependent's coverage would otherwise end because:

- your employment ends for any reason other than your gross misconduct.
- your hours of work are reduced so that you are no longer an eligible employee.
- you are divorced.
- you die.
- your child is no longer eligible to be a covered dependent (for example, because he or she reaches the limiting age)

How do I continue coverage?

If your coverage would end because of divorce or because your child is no longer eligible to be a dependent, you or your covered dependent must notify the Human Resources Department. If the Human Resources Department is not notified within 30 days of the date that coverage would otherwise end, coverage cannot be continued.

When the Human Resources Department receives this notice (or when your employment ends, your hours of work are reduced so you are no longer an eligible employee, or your death), you and your covered dependents will be notified about your/their right to continue coverage. If you or a covered dependent want to continue coverage you, he or she must elect to do so within 60 days of the date the notice was received. (You and each of your covered dependents can individually decide whether or not to continue coverage, but the election of coverage by you or your spouse will be considered to be an election by all covered individuals, unless another covered individual rejects coverage.)

Continuation coverage is identical to the coverage provided to similarly situated, active employees and their family members. If coverage for similarly situated active employees and their family members is modified, your continuation coverage will also be modified in the same manner. You will be notified of any such change in advance.

How long will Continuation Coverage last?

If coverage would otherwise end because your employment ends or your hours are reduced, so you are no longer an eligible employee; or coverage would otherwise end for a covered dependent (spouse or child) because of a divorce, death or a child's loss of dependency status, continuation of coverage for you and/or your covered dependents may continue until the earliest of the following:

- the end of the current Plan Year
- the date on which a premium payment was due but not timely paid.
- the date FMOLHS terminates its Flexible Spending Accounts.

Payment for Continuation Coverage

Once Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Plan and Continuation Coverage is available from the third party administrator, who is:

Voya Financial
P.O. BOX 929
Manchester, NH 03105
(833)232-4673
HASInfo@voya.com

Current Address

In order to protect your family's rights, you should keep the Plan Administrator (identified in the "GENERAL PLAN INFORMATION" Section) informed of any changes in the addresses of family members.

BENEFITS

What benefits are available under the Plan?

The Plan offers the following benefits*:*

Medical flexible spending account
Health savings account and
Limited Use FSA
Premium Expense account
Hourly Pay Differential

Are the benefits available to all Plan Participants?

No. A ***Class A Participant*** can elect to participate in the medical flexible spending account, the Health Savings Account, the Limited use FSA, or the Premium expense account. A **Class B Participant** can elect to receive the Hourly Pay Differential.

Benefits Available only to Class A Participants.

Qualified medical flexible spending expenses

If you elect to contribute to a *qualified medical flexible spending account*, the *Plan* will reimburse you for *qualified medical flexible spending expenses* which are *incurred* by you, your *spouse*, or your *dependent*s during the *Plan Year*. The maximum annual reimbursement limit on and after January 1, 2024 is $3,050.

Grace period

To the extent that you have an unpaid balance remaining in your *qualified medical flexible spending account* at the end of the *Plan Year*, the *Plan* will also reimburse you for *qualified medical flexible spending expenses* which are *incurred* by you, your *spouse*, or your *dependent* on or before March 15 (i.e., 2 ½ month period) immediately following the end of the *Plan Year*.

Claims *incurred* during the Plan Year and the *grace period* shall be applied to the balance remaining in your account in the order that they are received, regardless of the date-of-service. The *grace period* will only be extended to individuals who are active participants on the last day of the *Plan Year*.

Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount you elected under your *salary contribution agreement* for the *Plan Year*.

If you also participate in a health reimbursement arrangement account under *Code* §§ 105 and 106 offered by the *Plan Sponsor*, the reimbursement of *qualified medical flexible spending expenses* under this *Plan* is not available for *qualified medical flexible spending expenses* that are covered by the health reimbursement account until the amount available from the health reimbursement account covering those same *qualified medical flexible spending expenses* has been exhausted.

If you have an unpaid balance remaining in your *qualified medical flexible spending account* at the end of the *Plan Year (December 31)* , and if you have elected to participate in the *Plan Sponsor*'s high deductible health plan and also in the *Health Savings Account for the following Plan Year*, then your balance remaining in the *Qualified Medical*

FSA will automatically be rolled over into the Limited Use FSA, as required by law. The *Limited Use FSA* will reimburse you for eligible dental and vision expenses which are incurred by you, your spouse or your dependent on or before March 15 (i.e., 2 ½ month period) immediately following the end of the Plan Year.

What are *qualified medical flexible spending expenses*?
Qualified medical flexible spending expenses are *health care expenses* which are excludable from income according to *Code* § 105(b). *Qualified medical flexible spending expenses* may not be otherwise reimbursable under the *benefit plan* or other plan or by any other entity, and they may not be claimed as a tax deduction by the *participant*. *Qualified medical flexible spending expenses* do not include the cost of insurance premiums.

What are examples of qualified and non-*qualified medical flexible spending expenses*?
The examples listed in this section are intended only to give you a convenient reference to the types of expenses that may be eligible for reimbursement. Determination of *qualified medical flexible spending expenses* will be in accordance with those expenses *incurred* for medical care, as defined in *Code* § 213(d) of the Internal Revenue Code as stated at the time the expense is *incurred*, unless the Plan Sponsor has specifically excluded such charges as outlined below.

Examples of *qualified medical flexible spending expenses* include:

- Acupuncture
- Alcoholism treatment
- Allergy tests and shots
- Ambulance services
- Artificial limbs
- Automobile modifications required by medical conditions
- Braille materials (books and magazines)
- Chiropractic services
- Christian Science practitioner fees
- Co-payments
- Contact lenses and supplies
- Crutches
- Deductibles on your and your *spouse*'s group plan
- Dental services (not cosmetic)
- Dentures
- Eyeglasses, including examination fees
- Healing services
- Hearing aids and batteries
- Hospital costs not covered by a group health plan
- Insulin
- Laboratory fees
- Laetrile by prescription
- Mental health care and fees
- Non-prescription drugs and medicines that are *health care expenses* and for which you have a valid prescription
- Nurses' fees

- Obstetrical expenses
- Orthodontic services, if medically necessary
- Orthopedic shoes prescribed by a physician
- Osteopaths' fees
- over-the-counter drugs and medicines purchased without a prescription and over-the-counter menstrual care products
- Oxygen
- Physicians' fees not covered by medical plan
- Podiatrists' fees
- Prescription drugs
- Radial keratotomy
- Ramps required by medical conditions
- Rental of medical equipment
- Routine physical examinations
- Seeing eye dogs and their upkeep
- Smoking cessation programs, only if monitored by a licensed practitioner
- Special communications equipment for the deaf
- Surgery
- Therapeutic care for substance abuse (drug or alcohol)
- Weight loss programs prescribed by physicians for specific health problems
- Wheelchairs
-

Examples of non-*qualified medical flexible spending expenses* include:

- Birth control expenses
- Birth prevention surgery
- *Cosmetic surgery*, except those procedures necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- Expenses that do not comply with the Ethical and Religious Directives for Catholic Health Care Services
- Expenses related to procedures for infertility or any related treatment or procedure or any examination or diagnosis made in connection herewith
- Funeral expenses
- Health insurance premiums
- Surgical expenses related to treatment of obesity or any related treatment or procedure or any examination or diagnosis made in connection herewith
- Maternity clothes
- Nursing home expenses
- Expenses related to any diagnosis, treatment or procedure relating to a sexual dysfunction or inadequacy

This list should not be considered all-inclusive, and determination of non-qualified expenses will be in accordance with Internal Revenue *Code* §§ 105(b) and 213(d) as stated at the time the expense is *incurred*, unless the Plan Sponsor has specifically excluded such charges in the list above.

Health Savings Account

If you elect to enroll in the Plan Sponsor's high deductible health plan, then you may be an "*HSA-Eligible Individual*" and may elect to participate in the *Health Savings Account* ("HSA") benefit. The HSA benefit includes (a) a Non-Elective Employer Contribution to your HSA; and (b) the ability for you to contribute on a pre-tax salary reduction basis to an *HSA* account. Your *HSA* would be established and maintained outside the Plan by a vendor which has agreed with the *Plan Sponsor* to accept contributions for your account. Effective January 1, 2024, Voya Financial. will establish the HSAs.

Your voluntary salary reduction contributions can be increased, decreased, or revoked prospectively at any time during the Plan Year. To be eligible for this benefit, you must be an *HSA-Eligible Individual* and establish an *HSA* through Voya Financial.

The maximum amount of contribution (Plan Sponsor and employee) to an HSA for 2024 is $4,150 for self-only coverage or $8,300 for family coverage. The annual limit is increased by $1,000 if you reach age 55 by the end of the tax year. In 2024, the Plan Sponsor will make a Non-Elective Employer Contribution as set forth in its Health Plan. Any balance remaining in the *HSA* at the end of any Plan Year will be carried forward and used to fund such benefit in any subsequent *Plan Year*. The *HSA* is portable, which means that if you leave your employment with any *Participating Employer*, you can take your *HSA* account funds with you.

The *HSA* is not an employer-sponsored benefit plan, but it is an individual account separate from the Plan. The Plan Sponsor has no authority or control over the funds deposited into an *HSA*. Its role is limited to making automatic deductions of your contributions, and remitting your contributions and any Non-Elective Employer Contribution to the Plan Sponsor-approved vendor. If you make a claim for benefits under the *HSA*, it must be pursued under the claim procedures of Voya Financial.

Limited Use Flexible Spending Account ("Limited Use FSA").

The *HSA* can be a valuable method of saving money to pay for your qualified medical expenses. It is not available to you if you have a qualified medical flexible spending account, but is available to you if you are enrolled in the high deductible health plan. However, as of January 1, 2019, a participant in the high deductible health plan can have both an *HSA* and a "*Limited Use FSA*" at the same time. The *Limited Use FSA* works like the qualified medical FSA, but the *Limited Use FSA* can reimburse you only for eligible dental and vision expenses. Examples of dental expenses you can pay with a *Limited Use FSA* include: braces, dental services such as fillings, mouth guards, orthodontia services, and tooth removals. Examples of vision expenses you can pay with a *Limited Use FSA* include contact lenses and solutions, eyeglasses and frames, vision exams, and Lasik eye surgery. The maximum annual reimbursement limit on and after January 1, 2024 is $3,050. (Note: The limit is determined by combining the amount in the qualified medical flexible spending account and the *Limited Use FSA*.)

Grace Period For Limited Use FSA

To the extent that you have an undistributed balance remaining in your *Limited Use FSA* at the end of the Plan Year, the Plan will reimburse you for dental expenses and vision expenses which are incurred by you, your *spouse*, or your *dependent* on or before March 15 (i.e., a 2 ½ month period) immediately following the end of the *Plan Year*. Claims *incurred* during the *Plan Year* and the *grace period* will be applied to the balance remaining in your account in the order received, regardless of the date-of-service. The grace period will only be available to individuals who are active participants on the last date of the *Plan Year***.**

Debit card feature

Qualified medical flexible spending expenses may be purchased directly from the merchant or provider of services through the use of a *debit card*. This is a very convenient way to access the benefits of the *Plan*. Here is how the *debit card* feature works:

When you enroll in the *Plan* each year, you must certify that the *debit card* will only be used for *qualified medical flexible spending expenses*, as defined in *Code* § 213(d). You must also certify that you will not pay any expense with the *debit card* that has been reimbursed and that you will not seek reimbursement for the expense under any other plan covering health benefits. The certification will be printed on your *debit card*, and by using the card, you will reaffirm the certification each time you use the *debit card*.

When you use the *debit card* at the point-of-sale, the merchant or provider of service is paid the full amount of the *qualified medical flexible spending expense* (assuming there is sufficient coverage in your account) and your maximum available coverage remaining is reduced by that amount. Your use of the *debit card* is limited to the maximum dollar amount of coverage available in your *qualified medical flexible spending account*.

Your *debit card* is ineffective except at those merchants and providers of service authorized by the *Plan*, so that the use of the card at other merchants or service providers will be rejected. The *Plan* limits the *debit card* use to specified Merchant Codes relating to covered health care. Thus, the *debit card* use is limited to physicians, pharmacies, dentists, vision care offices, hospitals and other medical care providers of service.

You must agree to acquire and retain sufficient documentation for any expense paid with the *debit card*, including invoices and receipts where appropriate. All charges to the *debit card* are treated as conditional pending confirmation of the eligibility of the charge through your documentation. Within 30 days of using your *debit card*, you must submit an invoice or receipt from the merchant or provider of service, including the information required under the Section "How do I file a claim for *qualified medical flexible spending expenses*."

Substantiation of *qualified medical flexible spending expenses* will be satisfied without additional documentation when:

- The dollar amount of the transaction at a health care provider exactly equals the dollar amount of the copayment under the *benefit plan* for that service;
- The expense is a recurring expense that exactly matches a previously approved *qualified medical flexible spending expense* at this provider for the same time period;
- Verification is provided to the *Plan* through "real-time substantiation" that the expense is a *qualified medical flexible spending expense* by the provider of service, merchant or independent third party (e.g., Pharmacy Benefit Manager).

If the *Plan Administrator* finds that any claims have been paid that are not for *qualified medical flexible spending expenses*, you are required to refund any amount so identified to the account. If you fail to promptly refund the overpayment to the *Plan*, the amount may be withheld from your wages or other compensation to the extent permitted by law. In addition, the *Plan* reserves the right to suspend your use of the *debit card* and/or credit the overpayment against other *qualified medical flexible spending expenses* that you may submit until the overpayment refund is satisfied.

Your *debit card* will automatically be cancelled if your employment terminates or if your participation in the *plan* otherwise terminates, regardless of any applicable *grace period*.

Your debit card will pay for qualified medical expenses using the following ordering of available funds: (i) Limited use FSA, (ii) Medical FSA and (iii) HSA.

How do I file a claim for benefits under a *qualified medical flexible spending account* if it is not a self-substantiating debit charge?

You must submit a properly completed and documented claim to:

ONLINE:
myhealthaccountsolutions.voya.com

MOBILE ACCESS:
Download Mobile App – Voya Financial, Health Account Solutions

EMAIL TO:
HASInfo@voya.com

MAIL TO:
Voya Financial
P.O. Box 929
Manchester, NH 03105

FAX TO:
Voya Financial
(855) 370-0670

It must include the following information:

- The name of the person or persons on whose behalf the expenses have been *incurred*.
- The nature of the expenses *incurred* (that is, a description of the services or supplies being claimed).
- The date the expenses were *incurred*.
- Evidence that such expenses have not otherwise been paid, or are otherwise payable, through any coverage (insured or self-insured) or fee-for-service arrangement, or from any other source.

The claim must include written evidence from an independent third party documenting the above information. If the expenses are not reimbursable under any *benefit plan*, include a copy of the provider's statement that shows the date(s) of service, an explanation of services, and the name of the provider, along with a copy of the Explanation of Benefits or denial letter(s) from the *benefit plan*(s). Canceled checks or balance due statements are not acceptable.

You must also submit a signed statement in a form furnished and approved by the *Plan Administrator* certifying that the expenses for which you are seeking reimbursement are expenses which you believe in good faith are eligible for reimbursement under the *Plan*.

The *Plan Administrator*, in its sole discretion, reserves the right to verify to its satisfaction the eligibility of all claimed expenses prior to reimbursement and to refuse to reimburse any amounts that it determines are not eligible for reimbursement under this *Plan*.

The *Plan* will pay properly submitted claims for reimbursement at such intervals as the *Plan Administrator* may consider appropriate.

Is there a time limit for filing claims?
All claims for reimbursement must be submitted within 90 days following the end of the *grace period,* or the claims will be denied.

Special Temporary Rules. The Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the National Emergency or by such other date announced by the Agencies in a future notification, for all Plan participants, beneficiaries, qualified beneficiaries or claimants wherever located in determining the following periods and dates:

(a) The 30-day period (or 60-day period, if applicable) to request special enrollment under IRC Section 9801(f); and

(b) The date within which claimants may file a benefit claim, appeal of an adverse benefit claim, request an external review (as applicable), or file information to perfect a request for external review upon a finding that the request was not complete.

Is there a minimum claim amount?
There is no minimum amount you must submit for reimbursement for *qualified medical flexible spending expenses*

What if my *qualified medical flexible spending account* balance is less than my claim?
Reimbursement for *qualified medical flexible spending expenses* is limited to the annualized amount that you have elected to reduce your salary or wages and contribute to the *qualified medical flexible spending account* for the *Plan Year* under a valid *salary contribution agreement*.

To the extent that it is not used to pay claims, the amount of contributions to your *qualified medical flexible spending account* will accumulate throughout the *Plan Year*. If you submit an eligible claim during the *Plan Year* in an amount that exceeds your current *qualified medical flexible spending account* balance, the *Plan* will reimburse your claim expense up to the annualized amount of contributions, less any amounts already used to pay claims. Your Salary Contribution Agreement amount will continue to be taken for the remainder of the *Plan Year*.

What if I do not use all of the money in my *qualified medical flexible spending account* or my Limited Use FSA?
You have 90 days after the end of the *grace period* to file any *qualified medical flexible spending expenses* and limited use FSA *expenses incurred* for that year. If you fail to file for reimbursement within this time limit, or if you did not incur enough *qualified medical flexible spending expenses* or limited use FSA *expenses* to meet your annual salary contribution amount to each respective account, you forfeit any unused funds in your account. The Plan Sponsor can apply those funds to administrative expenses or as otherwise permitted by law.

Premium Expense Account
A *Premium Expense Account* allows eligible employees to use tax-free dollars to pay for certain premium expenses under various insurance programs offered by FMOLHS.

What insurance programs are eligible for the *Premium Expense Account*?
These premium expenses include:

- Health care premiums under our self-funded medical plan
- Dental insurance premiums
- Vision insurance premiums
- Group term life insurance premiums
- Accidental death and dismemberment insurance premiums
- Disability insurance premiums
- Other pre-tax insurance premiums for coverage that we may provide.

Under our plan, we will establish sub-accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

How do I file a claim for benefits under an insurance product covered under the Premium Expense Account? Claims submission is subject to the specific provisions of that Plan Document, insurance certificate or insurance policy.

Benefits Available Only to Class B Participants - Hourly Pay Differential

Effective on and after January 1, 2024, the only employee eligible to elect FPTNB position is one who is working in the position detailed in Exhibit A; and the only employee eligible to elect FTNB position is one who is working in the position detailed in Exhibit B; If you qualify to elect a FPTNB/FTNB position you have the ability to elect between receiving the Hourly Pay Differential or continuing to participate in all Employer benefit plans for which you are otherwise eligible. If you elect to receive the Hourly Pay Differential, then, you will be ineligible to participate in any benefit plan sponsored by the Employer (other than retirement plans), and you will not earn paid time off ("PTO"), short term disability benefits, holiday pay, or receive employer contributions to the retirement savings plan. If you are a new hire, you must make an election to FTNB position within the first 30 days of employment. If you are a transfer into a FTNB position, you would make an election prior to your status change to FTNB. To elect the Hourly Pay Differential, you need to timely complete and return the FPTNB or FTNB Agreement/Enrollment Form which, absent a Special Enrollment Period, would be binding for the balance of the Plan Year. At the next open enrollment period, you may choose to remain a FPTNB/FTNB Employee or to cease to be a FPTNB/FTNB Employee. To remain a FPTNB/FTNB Employee, you need to timely complete and return a FPTNB or FTNB Agreement/Enrollment Form. If you do not timely complete and return a FPTNB or FTNB Agreement/Enrollment Form, you will be treated as not having elected FPTNB/FTNB Employee status for the next Plan Year.

FUNDING

How is a *premium expense account* funded?

Your *premium expense account* is funded by the amounts you elect to contribute to the account by executing a valid *salary contribution agreement*. Your *premium expense account* will be used to pay for insurance premiums on a pre-tax basis.

How is a *qualified medical flexible spending account* or limited use FSA funded?

Your *qualified medical flexible spending account or Limited use FSA* is funded by the amounts that you elect to contribute to the account by executing a valid *salary contribution agreement*. *Qualified medical flexible spending expenses* will be reimbursed to you from the qualified medical flexible spending account to the extent of the amount you have elected to reduce your salary or wages for the *Plan Year* under a valid *salary contribution agreement*. *Qualified medical flexible spending expenses* which are limited to vision and dental expenses will be reimbursed to you from the Limited use FSA to the extent of the amount you have elected to reduce your salary or wages for the *Plan Year* under a valid *salary contribution agreement*.

Your annual salary or wage may be reduced in an amount not to exceed the amount established by the *Plan Sponsor* for each *Plan year*. The salary contribution amount elected will be funded pro rata over the number of consecutive pay periods in the *Plan Year*.

The *Plan Administrator* will establish an individual *qualified medical flexible spending account* and/or Limited use FSA, as applicable, for each *participant*, and will credit to each *participant's* account the salary contribution amounts elected. The *Plan* will reimburse you for *qualified medical flexible spending expenses* as described in the "Benefits" section.

How much can I elect to contribute to my *qualified medical flexible spending account or Limited use FSA*?

You may contribute an amount to a *qualified medical flexible spending account* or Limited use FSA not to exceed the maximum allowable annual contribution of $3,050. If you begin participation in the middle of the Plan Year, you may contribute up to the maximum allowable annual contribution less any amounts that you have contributed to any other *qualified medical flexible spending account or Limited use FSA* during the *Plan Year*.

Minimum Election Amounts

There is no minimum amount you must elect to contribute to your *qualified medical flexible spending account* or to your limited use FSA *account* each year.

Order of funding

The total salary contribution amount for this *Plan* for any one time period may not exceed the amount of your salary or wages for that period. In the event that the total elected amount exceeds your salary or wages for a period, amounts available shall be used to fund the accounts in the following order: the *premium expense account*, then the *qualified medical flexible spending account.* The total salary contribution amount will be reduced by the amount it exceeds your salary or wages for that period; however, future contributions will be adjusted to compensate for such reduction.

Accounting

The *Plan Administrator* will maintain complete records of all amounts to be credited for the *premium expense account* and amounts to be credited as a contribution or debited as a reimbursement of *qualified medical flexible spending expenses* or limited use FSA *expenses* on behalf of each *participant*. All contributions will be held as part of the general assets of the P*articipating employer*. No trust fund will be established and no other segregation or investment of assets will be made to maintain accounts of contributions under this *Plan*.

SALARY CONTRIBUTION AND DISCRIMINATION

Election period for salary contribution

In order to fund a premium expense account or *flexible spending account (medical or limited use)* or for a *Plan Year*, you must complete and file with the *Plan Administrator* an appropriate *salary contribution agreement* election form as described in the section, "Eligibility for Participation." You should consider carefully the amount of salary contribution you elect for each account because you will forfeit any unused amount at the end of the *grace period*. (Remember, the HSA funding is subject to special rules.)

Termination, revocation, or amendment of salary contribution elections

Your *salary contribution agreement* election for a *Plan Year* will terminate at the end of the *Plan Year*. You must make an affirmative election for a new salary contribution for each *Plan Year*.

Termination, revocation, or amendment of salary contribution elections may only be made by you in accordance with the section, "Eligibility for Participation," "May I make mid-year changes?"

Forfeiture of salary contribution amounts

If you fail to claim any amounts in the *qualified medical flexible spending account or, limited use FSA account* within the time limits specified in the section, "Benefits," "Is There a Time Limit for Filing Claims?," such amounts will be forfeited by you to the *Plan Sponsor*. The Plan Sponsor will determine how forfeited salary contribution amounts will be utilized.

Reduction of salary contribution elections to prevent discrimination in favor of prohibited group(s)

The *Plan* is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits and is intended to comply in this respect with the requirements of the *Code*. If, in the judgment of the *Plan Administrator*, the operation of the *Plan* in any *Plan Year* would result in such discrimination, then the *Plan Administrator* shall select and exclude from coverage under the *Plan* such highly compensated individuals who are *participants*, and/or reduce contributions under the *Plan* by highly compensated individuals who are *participants*, to the extent necessary to assure that, in the judgment of the *Plan Administrator*, the *Plan* does not discriminate.

The *Plan Administrator* will have the full authority to reduce the salary contribution elections of *participants* who are members of the prohibited group(s) under *Code* §§ 105(h) or 125, to the extent necessary to prevent the *Plan* from discriminating in favor of such prohibited group(s).

Determination of noncompliance

In the event that a determination is made that all or any part of the contributions to the *Plan* do not qualify as non-taxable contributions to a "cafeteria plan" under *Code* § 125, the affected contributions made by any *participant* will be treated as salary, and any unpaid balance in the *qualified medical flexible spending expense account or limited use FSA* will be returned to the *participant*. The *participant* must pay:

- Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed;
- The *participant's* share (as determined in good faith by the P*articipating employer*) of any applicable FICA or FUTA contributions which would have been withheld from such amounts by the P*articipating employer*

had such amounts been treated as salary and not as *qualified medical flexible spending expenses* or limited use FSA *expenses*; and

- An amount (as determined in good faith by the *Participating employer*) equal to the portion of any applicable penalties and interest payable by the *Participating employer* as the result of the failure to withhold and pay such amounts to the appropriate payee allocable to the *participant*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the* Plan*?

The *Plan Administrator* has retained the services of the *third party administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are not *qualified medical flexible spending expenses*), to decide disputes which may arise relative 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* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *participant* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *participant's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a *third party administrator* to pay claims;
- To establish and communicate procedures to determine whether *MCSOs and NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan*'s administration.

May changes be made to the* Plan*?

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* 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*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided to the extent required by law.

If the *Plan* is terminated, the rights of *participants* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

Additional operating rules*.*

A *participant's* salary contribution amount will not be subject to federal income tax withholding or to applicable Social Security (FICA or FUTA) tax withholding. Salary contribution amounts will not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.

Salary contribution amounts under this *Plan* shall not reduce salary or wage for purposes of any other employer sponsored employee benefit programs unless the provisions of those programs otherwise provide.

MISCELLANEOUS INFORMATION

Will the* Plan *release my information to anyone?

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the* Plan *makes an error?

Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate participation nor cause participation to be in force or to continue in force. Rather, the effective dates of participation shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

In the event that it has determined that the *Plan Administrator* has mistakenly reimbursed an expense which did not qualify under the terms of the *Plan*, the *Plan Administrator* may adjust your pay and appropriately credit the *qualified medical flexible spending account*.

Will the* Plan *conform with applicable laws?

This *Plan* shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *Plan Document*. It is intended that the *Plan* will conform to any applicable law.

When must legal actions be filed?

Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the *qualified medical flexible spending expenses* are *incurred* or are alleged to have been *incurred*. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claims Review Procedures."

What constitutes a fraudulent claim?

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of participation under this *Plan*:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person other than you, your *spouse* or your *dependent* according to the *Plan*;
- Attempting to file a claim for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or

- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?

The use of masculine pronouns in this *Plan Document* shall apply to persons of both sexes unless the context clearly indicates otherwise. 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. The use of the words, "you" and "your" throughout this *Plan Document* applies to *participants*.

How may a* Plan *provision be waived?

No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this* Plan Document *a contract between the employer and* participants*?

This *Plan Document* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *Plan Document* shall not be deemed to constitute a contract of any type between a *Participating Employer* 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 a *Participating Employer* or to interfere with the right of the *Participating Employer* to discharge any *employee* at any time.

May I appoint an authorized representative?

A *participant* is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. To appoint such a representative, the *participant* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator.* In the event a *participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *participant,* unless the *participant* directs the *Plan Administrator,* in writing, to the contrary.

How will the* Plan *pay benefits?

All benefits under this *Plan* are payable, in U.S. Dollars, to the *participant* or, if appropriate, the *alternate recipient*. In the event of the death or incapacity of a *participant* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his estate, the *Plan Administrator* may, in its sole discretion, make any and all payments due under the *plan* to the individual or institution which, in the opinion of the *Plan Administrator,* is or was providing the care and support of such *participant*.

What if my claim is for non-U.S. Providers?

Qualified medical flexible spending expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a *"non-U.S. provider"*) may be reimbursed under the following conditions:

- The *participant* is responsible for making all payments to *non-U.S. providers,* and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all requirements under *Code* § 105; and

- Claims for benefits must be submitted to the *Plan* in English.

How will the* Plan *recover payments made in error?

Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *participant* on whose behalf such payment was made.

A *participant, spouse*, *dependent,* provider, another benefit plan, insurer, or any other person or entity who receives a payment made in error under the terms of the *Plan,* shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum or other arrangement, as agreed.

Participants accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with the requirements of this *Plan*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* shall be entitled to recover its litigation costs and actual attorneys' fees *incurred*.

How will the* Plan *handle* medical child support order*s?

The *Plan Administrator* shall adhere to the terms of any *medical child support order* that satisfies the requirements of this section and Section 609 of *ERISA*. The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a *medical child support order* that is a *qualified medical support order* if such an individual is not already covered by the *Plan* as a *dependent*.

The *Plan Administrator* shall promptly notify the *participant* and each *alternate recipient* of:

- The receipt of a *medical child support order* by the *Plan*; and
- The *Plan's* procedures for determining the qualified status of *medical child support orders*.

Within a reasonable period after receipt of a *medical child support order*, the *Plan Administrator* shall determine whether such order is a *qualified medical child support order* and shall notify the *participant* and each *alternate recipient* of such determination. If the *participant* or any affected *alternate recipient* disagrees with the determinations of the *Plan Administrator*, the disagreeing party shall be treated as a claimant and the claims procedure provided in the section, "Claims Review Procedures," of the *Plan* shall be followed. The *Plan Administrator* may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the *Plan*.

Upon receiving a *national medical support notice*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the *Plan*, and if so:
    - Whether the child is covered under the *Plan*; and

- Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *medical child support order* or a *national medical support notice*; and
- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

Payments made under this *Plan* pursuant to a *medical child support order* described in this section in reimbursement for expenses paid by the *alternate recipient* or the *alternate recipient*'s custodial parent or legal guardian shall be made to the *alternate recipient* or the *alternate recipient*'s custodial parent or legal guardian.

CLAIMS REVIEW PROCEDURE

Premium Expense Account

Claims review procedures and appeal processes for adverse benefit determination for all insurance products covered under the Premium Expense Account can are subject to the specific provisions of that plan document, insurance certificate or insurance policy.

Medical Flexible Spending Account and Limited use FSA

Upon receipt of complete information, the claim will be deemed to be filed with the *Plan*. The *third party administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *third party administrator* within 45 days from receipt by the *participant* of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of claim decisions

The *Plan Administrator* shall notify you*,* in accordance with the provisions set forth below, of any adverse benefit determination within the following timeframes:

- If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by you and the *Plan Administrator.*

Extensions*.* This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies you*,* prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an adverse benefit determination

The *Plan Administrator* shall provide you with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the *Plan Document* upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of your right to bring a civil action following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to you*,* free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, or a statement that such explanation will be provided to you*,* free of charge, upon request.

Appeal of adverse benefit determinations

Full and fair review of all claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- You the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the Plan did not rely upon their advice; and
- That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances.

Requirements for appeal

You must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, your appeal must be addressed as follows and mailed or faxed as follows:

MAIL TO:
Voya Financial
P.O. Box 929
Manchester, NH 03105

FAX TO:
Voya Financial
(855) 370-0670

EMAIL:
Voya Financial
HASinfo@voya.com

It shall be your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the *participant*;
- The *participant's* social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *participant* will lose the right to raise factual arguments and theories which support this claim if the *participant* fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the *participant* has which indicates that the *participant* is entitled to benefits under the *Plan*.

If you provide all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of notification of benefit determination on review

- The *Plan Administrator* shall notify you of the *Plan's* benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and content of notification of adverse benefit determination on review

The *Plan Administrator* shall provide you with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;

- Reference to the specific portion(s) of the *Plan Document* on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that the *participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *participant's* claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to your medical circumstances, will be provided free of charge upon request;
- A statement of your right to bring an action, following an adverse benefit determination on final review; and
- The following statement: "You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing documents in the event of an adverse determination
In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide you access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on review to be final
If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 30 days after the *Plan's* claim review procedures have been exhausted.

HSA
The outside vendor will have its own claim procedures for the HSA.

Special Temporary Rules. The Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the National Emergency or by such other date announce by the Agencies in a future notification, for all Plan participants, beneficiaries, qualified beneficiaries or claimants wherever located in determining the following periods and dates:

(a) The 30-day period (or 60-day period, if applicable) to request special enrollment under IRC Section 9801(f); and

(b) The date within which claimants may file a benefit claim, appeal of an adverse benefit claim, request an external review (as applicable), or file information to perfect a request for external review upon a finding that the request was not complete.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information:

Disclosure of s*ummary health information* to the *Plan Sponsor*

In accordance with *HIPAA's* Standards for Privacy of Individually Identifiable Health Information (the *"privacy standards"*), the *Plan* may disclose *summary health information* to the *Plan Sponsor,* if the *Plan Sponsor* requests the *summary health information* for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan;* or
- Modifying, amending or terminating the *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 protected health information *("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:

- 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*);
- 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*;
- 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;*
- 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;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- 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)
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of 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.*);

- 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; and
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor,* as required in § 164.504(f)(2)(iii) of the *privacy standards* (45 CFR § 164.504(f)(2)(iii)), is established as follows:

  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:

  - Appropriate personnel of the Human Resources department
  - Appropriate personnel of the Accounting department
- The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.
- In the event any of the individuals described above do not comply with the provisions of the *Plan* documents relating to use and disclosure of *PHI,* the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" functions shall have the meaning ascribed to it in 45 CFR § 164.504(a),

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan* documents have been amended to incorporate the above provisions; and
- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of certain enrollment information to the *Plan Sponsor*
Pursuant to § 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 disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor.*

Other disclosures and uses of *PHI*
With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards.*

HIPAA SECURITY PRACTICES

Disclosure of electronic protected health information ("*Electronic PHI*") to the Plan Sponsor for *plan administration* functions

In accordance with *HIPAA's* Security Standards for the Protection of *Electronic PHI* (the "*Security Standards"),* and to enable the *Plan Sponsor* to receive and use *Electronic PHI* for *plan administration* functions, the *Plan Sponsor* agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the *Electronic PHI* that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- Ensure that 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;
- 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 Security Measures to protect the *Electronic PHI*; and
- Report to the *Plan* any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the *Security Standards.*

Exhibit A – effective 1.1.2024

Grandfathered FPTNB Positions

Department Name	**Job-Code Description**	**Company Code**
Med Surg Neuro Interm-St Dominic Main Campus	Registered Nurse 2 NO BEN GF	208
Neuro CC-Lake Main Campus	Registered Nurse NO BEN GF	102
PACU (formerly Surgical)-Ascension Campus	Registered Nurse NO BEN GF	102
Trauma Neuro CC-Lake Main Campus	Registered Nurse NO BEN GF	102
Telemetry-Ascension Campus	Registered Nurse NO BEN GF	102
Med Surg Neurology-Lake Main Campus	Registered Nurse NO BEN GF	102
Medical-Ascension Campus	Licensed Practical Nurse NO BEN GF	102
Imaging-Lake Assumption Community Hospital	MRI Technologist 1 NO BEN GF	103
Respiratory-Ascension Campus	Registered Respiratory Therapist 1 NO BEN GF	102

Exhibit B – Effective 1-1-2024

Open FTNB Positions

Registered Nurse FT NO BENEFITS

9451F.2024

FINAL 2024 FMOLHS Cafeteria Plan_v2 LD.mmo_final

Final Audit Report 2023-12-20

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