MEDICA FLEXIBLE BENEFITS

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION (SPD)

Administered by Medica Self-Insured

MEDICA

JANUARY 1, 2023

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的 Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့ၢ်အဲၣ်ဒိးန့ၢ်တၢ်ကတိၤကျိးထံဝဲလၢအကလီန့ၣ်, ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ဒေလံာ်အှၣ်သးအကူအခၢ်ဖီခိၣ်ကဒါအခံန့ၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jiík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíįį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

COMIFB-0119-M

MEDICA MEMBER SERVICES

General Member Services:

1-800-918-6152 TTY Users: **711**

Find more information about your benefits by signing in to your secure member site at **Medica.com/SignIn**.

Welcome!

We're glad you're a covered person under the plan. Employee benefits can be complicated. The information found in the pages of this plan can help you better understand your coverage and how it works.

You may need to reference multiple sections to get a complete picture of your coverage and what you will pay when you receive services. The most specific section of this plan will apply.

Some terms used have specific meanings.

In this plan, the words "you," "your" and "yourself" refer to you, the covered person. See the **Definitions** section at the end of this document for more terms with specific meanings.

Table of Contents

Introduction

Medica (sponsor) has established the Medica cafeteria plan through which qualified employees are provided with a choice of taxable compensation or reducing salary to elect certain *qualified benefits*. The cafeteria plan is administered by Medica (plan administrator). The cafeteria plan is designed to permit a qualified employee to contribute on a pre-tax wage or salary reduction basis.

This document is not the plan document for the cafeteria plan. Please contact the plan administrator for the cafeteria plan document.

The component plan(s) described in this document are intended to qualify as *qualified benefits* under Code § 125 and applicable regulations and will be interpreted to accomplish that objective.

- The medical flexible spending account which is also sometimes referred to as a flexible spending arrangement (medical FSA) component is intended to qualify as a self-insured medical reimbursement plan under Code § 105(b).
- The dependent care assistance program (DCAP) is intended to qualify as a dependent care assistance program under Code § 129, and the dependent care expenses reimbursed under the DCAP are intended to be eligible for exclusion from participating employees' gross income under Code § 129(a).
- Sponsor may offer other qualified benefits not described in this document.

Although reprinted within this document, the medical FSA component and the DCAP are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The medical FSA component is also a separate plan for purposes of applicable provisions of ERISA, HIPAA and COBRA. In the event that the medical FSA component is determined not to be a separate plan, the plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the medical FSA component.

The HSA funding feature described in the HSA component is not intended to establish an ERISA plan or to otherwise be part of an ERISA benefit plan.

This document serves both as the written plan document and the summary plan description (SPD) for the medical FSA. The plan is intended to meet the requirements of the Internal Revenue Code of 1986 (Code) and ERISA, where applicable.

When changes are made to the plan, the plan administrator will notify you as required by law and those individuals will receive a new plan or an amendment to this plan.

This plan describes benefits for which you may elect coverage. Coverage is subject to all terms and conditions of the plan. As a condition of coverage under the medical FSA plan, you must consent to the release and re-release of medical information necessary for the administration of this plan. The confidentiality of such information will be maintained in accordance with existing law.

If this plan is translated into another language or an alternative format is used, this written English version governs all coverage decisions.

Medica's nondiscrimination policy

Medica's policy is to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, gender, gender identity, marital status, status with regard to public assistance, disability, sexual orientation, age, genetic information or any other classification protected by law.

If you have questions, call Member Services at one of the telephone numbers listed inside the front cover.

Plan Overview

The information contained in this section of the plan provides general information regarding the plan. It is important to remember that this section of the plan is only an overview. You also need to refer to the section that describes a particular plan requirement in detail.

General plan information

Plan Name

Medica

Sponsoring Employer (Sponsor), Address and Telephone Number of Sponsor

Medica
401 Carlson Parkway
P.O. Box 9310
Minneapolis, MN 55440-9310
(952) 992-3888

Plan Administrator, Business Address and Business Telephone Number of Plan Administrator

Medica
401 Carlson Parkway
P.O. Box 9310
Minneapolis, MN 55440-9310
(952) 992-3888

Agent for Service of Legal Process

Benefits Manager

Sponsor IRS Employer Identification Number (EIN)

41-1242261

Plan Year

January 1 through December 31

This is also your record keeping year.

Plan Number

501

Type of Plan

Section 125 cafeteria component plans offering:

- Medical and/or dependent care

- Expense reimbursement accounts
- Pre-tax funding for HSAs

Type of Administration

Plan administrator administration

The plan administrator has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the benefits provided under the plans. Medica's responsibilities generally consist of initially determining the validity of claims pursuant to the terms of the plan and administering benefit payments under this plan. The service agreement between the plan administrator and Medica is for administrative services only. Medica does not insure the provision of benefits under the plans; Medica is not a health insurer. Medica is a third party retained by the plan administrator. Medica is not a COBRA administrator.

Medica may arrange for various persons or entities to provide administrative services on behalf of Medica, including claims processing. You must cooperate with those persons or entities in the performance of their responsibilities.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

Benefits under the plan are paid from wages or salary reduction from covered employees taken on a pre-tax basis. Amounts withheld from your pay are held with the general assets of sponsor. Amounts withheld to fund your HSA will be deposited in the HSA account established by you.

Benefits

The medical FSA and the DCAP are furnished in accordance with this plan. The medical FSA plan provides an explanation of the benefits offered by the plan. If there is a conflict between any other document and the plan document, this plan document shall govern.

The benefits described in this plan document and summary plan description detail the benefits available under the plan. **What's Covered and How Much Will I Pay** describes the procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

HIPAA compliance

The medical FSA under the plan is subject to HIPAA privacy standards and HIPAA security standards and will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The privacy and security provisions of HIPAA do not apply to the DCAP and HSA.

The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). With some exceptions, protected health information or PHI is information that: (i) identifies or could reasonably be used to identify you and (ii) relates to your physical or mental health or condition, the provision of your health care or your payment for health care. The sponsor may use or disclose PHI received from the medical FSA or from another party acting on behalf of the medical FSA for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the medical FSA. However, with respect to such PHI, the sponsor agrees as follows:

1. The sponsor will not use or further disclose such PHI other than as permitted or required by this plan or as required by law (as defined in the HIPAA privacy standards).
2. The sponsor will ensure that any agents, including a subcontractor, to whom the sponsor provides PHI received from the medical FSA or from another party acting on behalf of the medical FSA, agree to the same restrictions and conditions that apply to the sponsor with respect to such PHI.
3. The sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the sponsor, except under an authorization which meets the requirements of the HIPAA privacy standards.
4. The sponsor will report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the sponsor becomes aware.
5. The sponsor will make available PHI in accordance with your right of access under the HIPAA privacy standards.
6. The sponsor will make available PHI for amendment and incorporate any amendments to PHI in accordance with the HIPAA privacy standards.
7. The sponsor will make available the information required to provide an accounting of certain disclosures of PHI in accordance with the HIPAA privacy standards.
8. The sponsor will make its internal practices, books and records relating to the use and disclosure of PHI received from the medical FSA or another party on behalf of the medical FSA, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the plan with the HIPAA privacy standards.
9. If feasible, the sponsor will return or destroy all PHI received from the medical FSA, or another party acting on behalf of the medical FSA, that the 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. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The sponsor will ensure that adequate separation between the medical FSA portion of the plan and the sponsor is established as follows:

    a. Only the following persons under control of the sponsor may be given access to the PHI that is disclosed:

       Benefits Manager, Director, Total Rewards

    b. The access to and use of PHI by the persons described above is restricted to the plan administration functions that the sponsor performs for the medical FSA.

    c. If any of the persons described above do not comply with the above provisions relating to HIPAA compliance, the sponsor will impose sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions may be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate. Sanctions, when imposed, will be commensurate with the severity of the violation.

11. The HIPAA security standards govern the security of electronic protected health information created, received, maintained or transmitted by the medical FSA. The sponsor agrees as follows:

    a. The sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the medical FSA.

    b. The sponsor will ensure that the adequate separation required by the HIPAA privacy standard is supported by reasonable and appropriate security measures.

    c. The sponsor will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect the information.

    d. The sponsor will report to the medical FSA any security incident of which it becomes aware.

ERISA Information

Statement of ERISA rights

This statement of ERISA rights applies to the medical FSA component plan. ERISA guarantees certain rights and protection to participants of benefit plans and certain others. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the plan for the sponsor. For purposes of this Statement of ERISA Rights only, the terms *you* and *your dependents* refer to covered employees and their dependents who have such rights and protections under ERISA.

You may examine, without charge, all plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You may examine copies of these documents in the plan administrator's office, or you may ask a supervisor where copies of the documents are available.

If you want a personal copy of plan documents or related material, you should send a written request to the plan administrator. You will be charged only a reasonable charge for the copies.

You are entitled to receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

You or your dependents are entitled to continue coverage under the plan if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this plan for information regarding COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. These individuals, called *fiduciaries*, have an obligation to administer the plan prudently and to act in the interest of plan participants and beneficiaries. The named fiduciary for this plan is the plan administrator. No one, including your employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. If the claim is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge. You have the right to have the plan administrator review and reconsider the claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan to provide you the materials and pay you up to $110.00 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court, after exhausting the plan's claims procedures. In addition, if you disagree with the plan's

decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

What's Covered and How Much Will I Pay

This section describes the services eligible for coverage and any expenses that you will need to pay.

COMPONENT PLAN BENEFITS

What's covered

The sponsor intends that payments made under a component plan will be tax-free to you under the Code. Thus, to the extent that your wage or salary is reduced to:

- Reimburse you for medical care received by you, your spouse or dependents (the medical FSA); or dependent care (the DCAP).
- Make HSA contributions.

You will not be federally taxed on the income. Of course, to the extent that you elect or are deemed to have elected to receive compensation instead of benefits, that compensation will be fully taxable to you.

What to keep in mind

The operation of flexible benefit plans is subject to certain non-discrimination rules established in the Code. Under those rules, only a certain amount can be contributed on behalf of highly-compensated or key employees of the sponsor. The sponsor reserves the right to change the elections of highly-compensated or key employees to ensure that the plan satisfies any non-discrimination rules that may be in place. You will be notified if your election is so affected. This plan will be administered in a manner that complies with the applicable provisions of the Code.

What's not covered

Except for an HSA, you will forfeit any amounts by which you have elected to have your wages or salary reduced for which a claim for reimbursement is not filed within the time period specified in this document. **Such amount cannot be carried over to another year or used for any other benefit plan.**

MEDICAL FLEXIBLE SPENDING ACCOUNT (MEDICAL FSA)

What's covered under your medical FSA

The medical FSA allows you to reduce your wages or salary to pay for certain qualifying medical expenses that are not covered by insurance. If you select reimbursement for medical expenses, your wages or salary will be reduced by the amount you have determined in your election to have withheld from your paycheck.

- The maximum amount that can be reimbursed to you under this plan for any plan year is $3,050.
- There is no minimum annual amount.

A medical expense qualifies for reimbursement if it is an expense incurred by you, your spouse (unless you have excluded your spouse from coverage) or your dependent, for medical care as defined in Section 213(d) of the Code, for the limited expenses listed later in this document, but only to the extent that you or the person incurring the expense is not reimbursed for the expense through any other accident or health plan.

If you elected to be covered under a limited medical FSA, only the limited expenses listed later in this document can be reimbursed from the account.

Qualifying expenses under a medical FSA are reimbursable for the plan year in which the expenses are incurred. An expense is incurred when the medical services are performed, not when the bill for the services is received. If you joined the plan after the beginning of the plan year, then expenses you incurred before you joined the plan cannot be reimbursed.

What's not covered under your medical FSA

You cannot pay premiums for health and/or dental insurance or long-term care insurance or any long-term care expenses or any HSA contributions through the medical FSA.

A qualifying medical expense does not include expenses for:

1. Cosmetic procedures, unless the procedure is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or disfiguring disease.

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

2. Qualified long-term care services (as defined in Section 7702B(c) of the Code);
3. The payment of premiums under any group or individual health or dental plan.

What to keep in mind under your medical FSA

Making your election

Each election for a reimbursement amount under your medical FSA that is filed with the cafeteria plan administrator is effective for an entire plan year. Once you have filed an election, **you may not change that election during the plan year** except under **Mid-year election changes** below.

Mid-year election changes

Below is a general description of events that will allow a change in election:

1. A change in status event. If you experience one of the following events and want to change an election during the plan year you must notify the plan administrator within 30 days of the event:
    a. A change in your legal marital status, including marriage, death of your spouse, legal separation or annulment;
    b. A change in the number of your dependents, including birth, death, adoption, placement for adoption or a child placed as a foster child;
    c. A change in the employment status of you, your spouse or your dependent including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in work site. In addition, if eligibility conditions of the benefit plan of the sponsor, or your or your dependent's employer depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the benefit plan, then that change constitutes a change in employment status;
    d. Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance;
    e. A change in the place of residence of you, your spouse or your dependent, if such change affects coverage under a health plan; or
    f. Any other event that the plan administrator determines will constitute a change in status event under the Code and its implementing regulations and rulings.
2. Compliance with a Qualified Medical Child Support Order (QMCSO) or other judgment, decree or order requiring health coverage for your child who is your dependent;
3. The election of COBRA continuation coverage by you, your spouse or dependent;
4. Other events the plan administrator determines will permit a change or revocation of an election during the plan year under the Code and its implementing regulations and rulings.

Full or limited medical FSA

1. Full medical FSA

You may choose to have the full range of medical expenses reimbursed under your medical FSA for the plan year or you may choose to participate in a limited medical FSA for the year.

All expenses for medical care defined in Section 213(d) of the Code incurred by you, your spouse, or dependent can be reimbursed through the plan that include:

- Hospital;
- Doctor;
- Dental;
- Drugs; and
- Over-the-counter drugs.

However, premiums for health and/or dental insurance or long-term care insurance or any long-term care expenses cannot be reimbursed through the medical FSA.

The full medical FSA is appropriate if you or your spouse will not contribute to an HSA during the plan year.

2. Limited medical FSA

A limited medical FSA is an account that pays only certain medical expenses. The expenses covered will be for:

- Dental; and
- Vision, including eyeglasses, to the extent not covered under your health insurance.

If you wish to fund an HSA and if you wish to be covered under a medical FSA, you must elect a limited medical FSA.

If you are covered under a full medical FSA for any month, you are not eligible to contribute to an HSA that month.

If your spouse is covered by a high deductible health plan and wishes to make contributions to an HSA, your spouse cannot be covered under your full medical FSA. Your spouse could be covered under your limited medical FSA and still be eligible to contribute to an HSA.

For employees eligible for limited wraparound coverage

If you are enrolled in a medical FSA, you are not eligible for any limited wraparound coverage.

Special extension for reimbursement of claims

Ordinarily you must incur a claim during the plan year in order to be reimbursed for that claim. As mentioned above, expenses are incurred when the medical services are performed, not when the bill for the service is received. Effective for the 2023 plan year, participants who are participating on the last day of the plan year can receive reimbursements for expenses *incurred*

during the 2½ month period following the close of the plan year, specifically until March 15th, 2024.

Reimbursement requests must still be *filed* by the last day of the fourth month following the end of the plan year. **You will forfeit** any amounts you have elected to have your wages or salary reduced for medical expenses and for which a claim is not filed within this incurred period. **Such amount cannot be carried over to another year or used for any other benefit plan.**

Expenses incurred after the end of the plan year that are submitted for reimbursement will be reimbursed first from amounts remaining from the prior plan year election. However, if expenses incurred in the prior year are later submitted for reimbursement, the accounts will be adjusted so that the prior year claims will be reimbursed from the prior year account, to the extent possible.

DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

What's covered under your DCAP

A DCAP allows you to reduce your wages or salary to pay for expenses incurred for the care of either:

1. Your dependent who is under the age of 13 years and with respect to whom you are entitled to an income tax exemption; or
2. Your dependent or spouse who is physically or mentally incapable of caring for him or herself; or
3. Such other dependents allowed under applicable law.

The plan administrator will make reimbursement payments daily.

To be reimbursed, expenses must meet each of the following criteria:

1. They must be incurred for the care of your dependent or for related household services;
2. They must be paid to a dependent care service provider; and
3. They must be incurred to enable you and your spouse to be gainfully employed for the period for which you have one or more qualifying dependents.

In addition, you will have to supply the taxpayer identification number of your day care provider in order to receive reimbursement.

Qualifying expenses under the DCAP are reimbursable for the plan year in which the expenses are incurred. An expense is incurred when the dependent care services are performed, not when the bill for the services is received. You can only be reimbursed for expenses incurred during the plan year and during the period you were covered by the plan. If you joined the plan after the beginning of the plan year, then expenses you incurred before you joined the plan cannot be reimbursed.

If your dependent is a child under the age of 13, you can be reimbursed for expenses incurred for services outside your household. If your dependent is not a child, but instead is another qualifying dependent (spouse or dependent who is physically incapable of caring for him or herself), you can be reimbursed for such outside expenses only if the qualifying dependent regularly spends at least eight hours a day in your household and must have the same principal place of abode as you for more than half the year.

- The maximum amount that you can elect to have reimbursed to you under this plan in any plan year is the *lesser* of:
    1. Your earned income;
    2. Your spouse's earned income; or
    3. $5,000 ($2,500 if you are married and file separate tax returns). If your spouse is a full-time student at an educational institution or physically or mentally incapable of

caring for him or herself and has the same principal place of abode as you for more than half the year, he or she is considered to have earned income of $250 per month if you have one dependent or $500 per month if you have two or more dependents.

- There is no minimum annual amount.

What's not covered under your DCAP

You may not be reimbursed for:

1. Payments to a facility which provides care to more than six individuals who do not live there (for example, a child care center or some family day care arrangements) unless the facility complies with all state and local laws;
2. Payments to a relative whom you could claim as a dependent or to your child who is under the age of 19; or
3. Overnight camp expenses.

What to keep in mind under your DCAP

Each election for a reimbursement amount under your DCAP filed with the plan administrator is effective for an entire plan year. Once you have filed an election, **you may not change that election during the plan year** except under the mid-year changes events described in **Mid-year election changes** below.

Mid-year election changes

Below is a general description of events that will allow a change in election:

Any revocation and new election must be on account of and consistent with:

1. A change in status event. If you experience one of the following events and want to change an election during the plan year you must notify the plan administrator within 30 days of the event:
    a. A change in your legal marital status, including marriage, death of your spouse, legal separation or annulment;
    b. A change in the number of your dependents, including birth, death, adoption, placement for adoption or a child placed as a foster child;
    c. A change in the employment status of you, your spouse or your dependent including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in work site;
    d. Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance;
    e. A change in the place of residence of you, your spouse or your dependent, if such change affects coverage under the DCAP; or

f. Any other event that the plan administrator determines will constitute a change in status event under regulations and rulings of the Internal Revenue Service.

2. Cost changes imposed by a dependent care provider who is not your relative;

3. Significant coverage changes with or without a loss of coverage, or the addition or improvement of a benefit package option;

4. A change in coverage under another employer plan if the other plan allows participants to make a change; or

5. Other events the plan administrator determines will permit a change or revocation of an election during the plan year under the Code and its implementing regulations and rulings.

Dependent care expenses reimbursed by the plan are not eligible for the dependent care tax credit available under Section 21 of the Internal Revenue Code. Under Section 21, the amount of child care expenses allowed as a tax credit may not exceed $3,000 (for one child) or $6,000 (for two or more children). The amount of the credit ranges from 35% to 20% of qualifying expenses for taxpayers with adjusted gross incomes above $43,000. Whether or not you should use the tax credit or the reimbursement provided under this plan depends upon your personal tax situation including your filing status and the amount of your taxable income. Taxable income means your gross income minus allowable deductions and exemptions. The choice also depends upon the tax rates and tax brackets (which are indexed annually for inflation). Please consult your own personal tax advisor or investigate this issue yourself to determine whether the tax credit or plan reimbursement offers greater savings.

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTIONS

What's covered under your HSA

You may elect to make contributions to a health savings account that you have established **if you elected coverage under a qualified high deductible group medical coverage plan and are not covered by any other plan that is not a qualified high deductible health plan**, including medical FSA, with few exceptions. You can be covered under a medical FSA if it is a medical FSA that covers only limited items. Therefore, you need to carefully consider your medical FSA before making an HSA election.

If you are eligible to contribute to an HSA, for 2023, the maximum contribution is:

- $3,850 for self-only coverage; or
- $7,750 for other coverage.

If you have reached age 55, you may contribute an additional $1,000 per year.

In addition to the wages or salary reduction contributions that you can make to your HSA, the employer may also choose to contribute to your HSA which would also count towards the total maximum contribution(s) above. If so, the employer will establish the amount that it will contribute to your HSA at the beginning of the year and will let you know if the amount changes during the year. The employer may choose to match a portion of your contribution to the HSA or may make additional contributions if you participate in a wellness program or disease management program. Your employer will let you know if you are eligible for any such HSA contributions.

What to keep in mind under your HSA

Changing your election

Each election that is filed with the plan administrator is effective for the plan year until changed. Unlike the situation with other component plans of the cafeteria plan, you may change your HSA election during the plan year for any reason. The change is made prospectively.

Each year you are given the opportunity to change your election. If you have elected HSA contributions, you must make an election each year to continue these contributions. If you do not make an election for HSA contributions, you will be deemed to have elected cash compensation in lieu of any such contribution regardless of the election you made during the prior plan year. However, if you fail to make an election during the designated time identified by the plan administrator and wish to make an election, you can file an election at any time during the plan year to be effective for future pay.

HSA not an employer plan

You own your HSA. The HSA is not considered an employer plan.

How Do I Submit a Claim

This section describes the process for submitting a claim.

CLAIMS FOR BENEFITS UNDER THE MEDICAL FSA

The Code requires a medical FSA administrator to obtain the following information regarding the health services for which you are seeking reimbursement under the plan:

- The individual(s) on whose behalf health services have been incurred;
- The nature and date of the health services;
- The amount of the requested reimbursement; and
- A statement that such health services have not otherwise been reimbursed and are not reimbursable through any other source.

For reimbursement of amounts that are your responsibility under the group medical plan, the explanation of benefits provided by the group medical coverage to Medica is treated as full substantiation. By enrolling in this plan, you certify that amounts submitted for reimbursement have not been reimbursed nor will you seek reimbursement from any other plan covering health benefits. For all other claims for reimbursement, you must submit a claim accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician or pharmacy) showing that the health services have been incurred and the amounts of such services, together with any additional documentation that Medica may request.

You must submit the claim in English via the online portal at **Medica.com/SignIn**, or through the Medica ONESource mobile application. If applicable, you can also use your debit card to make payment for eligible expenses in accordance with the terms of your debit card agreement. If you prefer, you may submit a Reimbursement Request Form to Medica at the address listed below. Your Medica identification number must be on the claim.

Claim forms can be downloaded by accessing your secure member account at **Medica.com/SignIn** or by calling Member Services at one of the telephone numbers listed inside the front cover.

You should retain copies of all claim forms and correspondence for your records.

Mail to:

Medica ONESource
PO Box 2804
Fargo, ND 58108-2804

You must submit claims no later than one hundred twenty (120) days after the close of the plan year in which the claim was incurred, or one hundred twenty (120) days from the date coverage ends due to termination of employment, whichever is earlier. Reimbursement requests filed after these dates will not be reimbursed.

Upon receipt of your claim for benefits, the plan will generally pay the reimbursement amount to you directly. However, the online portal offers you the option to pay the provider directly.

Medica will notify you of authorization or denial of the claim within 30 days of receipt of the claim.

If your claim does not contain all the information Medica needs to make a determination, Medica may request additional information. Medica will notify you of its decision within 15 days of receiving the additional information. If you do not respond to Medica's request within 45 days, your claim may be denied.

If you use your medical FSA debit card to pay expenses from the medical FSA, some expenses may be validated at the time the expense is incurred. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will not be permitted to obtain cash withdrawals at ATMs or obtain cash back from a merchant using your medical FSA debit card, and certain transactions for ineligible expenses will be denied at the point of sale.

Claims for services provided outside the United States

Claims for services rendered in a foreign country will require the following additional documentation:

- Claims submitted in English with the currency exchange rate for the date services were received.
- Itemization of the bill or claim.
- The related medical records (submitted in English).
- Proof of your payment of the claim.
- A complete copy of your passport and proof of travel.
- Such other documentation as Medica may request.

For services rendered in a foreign country, the plan will pay you directly.

The plan will not reimburse you for costs associated with translation of medical records or claims.

CLAIMS FOR BENEFITS UNDER THE DCAP

You must submit the following information, in writing, via the online portal at **Medica.com/SignIn**, or through the Medica ONESource mobile application:

- The amount, date, and nature of the expense;
- The name of the person or entity to which the expense was or is to be made;
- The taxpayer identification number of the person or entity to which the expense was or is to be paid;
- The name of the person for whom the expense was incurred;
- Original bills, invoices, receipts or other statements showing the amount of expenses, together with any additional documentation which the plan administrator may request;
- The Medica identification number; and
- Such other information as the sponsor may require from time to time.

Claim forms can be downloaded by accessing your secure member account at **Medica.com/SignIn** or by calling Member Services at one of the telephone numbers listed inside the front cover.

You should retain copies of all claim forms and correspondence for your records.

Mail to:

Medica ONESource
PO Box 2804
Fargo, ND 58108-2804

On or before January 31 of each year, the sponsor will furnish you with a statement showing the amount of reimbursement paid (or withheld) each year. This statement may also be viewed at the online portal, **Medica.com/SignIn**.

The plan administrator will make reimbursement payments daily. Reimbursement requests for expenses incurred during a plan year may be filed up to 120 days following the close of the plan year, or one-hundred-twenty (120) days from the date coverage ends due to termination of employment, whichever is earlier.

Upon receipt of your claim for benefits, the plan will generally pay the reimbursement amount to you directly. However, the online portal offers you the option to pay the provider directly.

CLAIMS FOR BENEFITS UNDER THE HSA

Claims for benefits under the HSA should be submitted to the trustee/custodian of the account you have established in accordance with its rules. You are responsible for showing that any distributions are eligible for tax-free treatment.

How Do I File a Medical FSA Complaint

This section describes the process for filing a medical FSA complaint. This section does not apply to the HSA or DCAP.

Claim denials

Medica will provide you with the following written information if a claim is denied (in whole or in part):

1. The reason(s) for the denial;
2. Reference to the provision(s) of the plan on which the denial is based;
3. A description of any additional material or information you must submit to complete processing of the claim and why such information is necessary; and
4. An explanation of the plan's claim review procedures.

Generally, Medica will notify you of denial within 30 calendar days after the plan receives proof of the claim. You can also view the denial on the portal, **Medica.com/SignIn**.

Reconsideration of claim denials

1. If you are dissatisfied with Medica's claim denial, you or an authorized representative may submit a written request for an appeal to Medica at the following address:

   Medica ONESource
   PO Box 2804
   Fargo, ND 58108-2804

   You must request an appeal within 180 days from the date of the claim denial. The appeal request should state the reasons you believe the claim denial was improper and should be accompanied by any additional information, material or comments you consider appropriate. You may also review any pertinent documents related to the claim.

2. The denied claim shall be reviewed by Medica and a decision made within 30 calendar days after receiving the written request for review. The decision of Medica shall be in writing and will include the specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.

Who's Eligible for Coverage and How Do They Enroll

This section describes who can enroll and how to enroll.

Who can enroll

To be eligible to enroll for coverage you must meet the eligibility requirements of the plan and be a qualified employee as defined in this plan to elect coverage under a component plan when they are eligible to participate in the cafeteria plan. Check the cafeteria plan document for eligibility criteria.

How to enroll

You must elect to enroll:

1. During the initial enrollment period as described in the cafeteria plan document; or
2. During the annual open enrollment period as described in the cafeteria plan document; or
3. At any time on a change in status as described in this section under **Mid-year changes** as described in this document; or
4. For HSA contributions only, elect at any time.

Initial enrollment and effective date of coverage

If you enroll when you first become eligible to participate in the cafeteria plan, the date on which you first meet the definition of a qualified employee.

Annual open enrollment and effective date of coverage

A period communicated by the plan administrator each year during which qualified employees may elect coverage generally for the upcoming cafeteria plan year.

For qualified employees and dependents who enroll during the annual open enrollment period, coverage begins on the first day of the cafeteria plan year for which the open enrollment period was held.

For qualified employees who elect HSA contributions, the HSA is effective the first day of the first calendar month following the date the written application has been received and approved by the plan administrator.

Changes and effective date of coverage

You should notify the plan administrator in writing within 30 days of the effective date of any changes to your name or address, changes to status of dependents or other relevant facts concerning you, your spouse or your dependents.

For qualified employees and dependents who enroll as a result of a change in status event, the first day of the first calendar month following the date the written application has been received and approved by the plan administrator.

When Does My Coverage End and What Are My Options for Continuing Coverage

When your coverage ends

This section describes when coverage ends under an FSA component plan on the same terms and conditions as set forth in the cafeteria plan document. When this happens you may exercise your right to continue your coverage as is also described in this section.

Continuing your coverage

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under federal law, to the extent the component plan is subject to COBRA.

Please note: All aspects of continuation coverage administration are the responsibility of the plan administrator.

Additionally, when you lose group health coverage, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You and your family may have coverage options through the Exchange, Medicaid or other group health plan coverage options (such as a spouse's plan). For example, you may be eligible to buy an individual or family plan through the Exchange. By enrolling in coverage through the Exchange, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

The paragraph below describes the continuation coverage provisions. Federal continuation is described in **Your right to continue coverage under federal law.**

If your coverage ends, you should review your rights under federal law with the plan administrator.

Your right to continue coverage under federal law

Notwithstanding the provisions regarding termination of coverage described in this section, you may be entitled to extended or continued coverage under COBRA as follows:

COBRA continuation coverage for medical FSA

To the extent the component plans are subject to COBRA, and to the extent required by COBRA, you, your spouse and dependents, as applicable, whose coverage terminates under the medical FSA because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the medical FSA the day before the qualifying event for the periods described by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contact the plan administrator for questions about paying for COBRA coverage.

USERRA continuation coverage

To the extent a component plan offered through the cafeteria plan is subject to this law, the plan shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 (USERRA), and in accordance with any policies and procedures adopted by the plan administrator. Contact the plan administrator for questions about USERRA.

Additional Terms of Your Coverage

This section describes the general provisions of the plan.

Applicable law

This plan is intended to be construed, and all rights and duties hereunder are to be governed in accordance with the laws of the State of Minnesota, except to the extent such laws are preempted by the laws of the United States of America.

Clerical error and misstatements

You will not be deprived of coverage under the plan because of a clerical error or misstatement by the plan or plan administrator. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination. If there is a clerical error or any misstatement of relevant facts pertaining to coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage.

Plan amendment and termination

Any change or amendment to or termination of the plan, its benefits or its terms and conditions, in whole or in part, whether prospective or retroactive, shall be made by the sponsor. You will receive notice of any amendment to the plan in accordance with and to the extent required by applicable law. No one has the authority to make any oral modification to the plan.

Covered employee rights

The action of the sponsor in creating this plan shall not be construed to constitute and shall not be evidence of any contractual relationship between the sponsor and any covered employee, or as a right of any covered employee to continue in the employment of the sponsor, or as a limitation of the right of the sponsor to discharge any of its employees, with or without cause.

Nondiscrimination

This plan is intended to be nondiscriminatory and to meet the requirements under applicable sections of the Code. Should a problem arise, the plan administrator shall determine the manner of correction and may do so with or without your consent.

Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) imposes certain obligations on employers with fifty (50) or more employees. To the extent the employer is subject to FMLA, this plan shall be administered in a manner consistent with the FMLA and the applicable employer's FMLA policy.

Discretionary authority

Discretionary authority is reserved to the plan administrator, the plan's named fiduciary and any other fiduciary to interpret and apply plan terms to the extent that such individual or entity is

acting in its fiduciary capacity. The claims administrator shall be a fiduciary for purposes of determining claims.

No guarantee of tax benefits

While the sponsor intends that the payments for benefits under the plan will be tax-free, the sponsor does not guarantee that this will, in fact, be the case. The sponsor has not requested the Internal Revenue Service to rule on whether the payments under the plan are tax-free and the sponsor does not intend to ask for such a ruling. Thus, it is possible that the Internal Revenue Service could successfully claim at some later date that you owe taxes on the amounts that you elected to reduce your wages or salary or HSA contributions. If that should happen, you (and not the sponsor) will be responsible for paying that tax.

Definitions

Words and phrases with specific meanings are defined in this section.

Benefits. The services eligible for coverage as described in this plan, including any amendments.

Cafeteria plan. A written plan that complies with the requirements of Code section 125 and its regulations, that is maintained by an employer for the benefit of its employees that offers employees the choice between at least one permitted taxable benefit and one or more qualified benefits.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and its implementing regulations.

Code. The Internal Revenue Code of 1986, as amended and its implementing regulations.

Component plan. A *qualified benefit* as described in the Code and section 125 implementing regulations.

Covered employee. A qualified employee who makes an election to reduce salary or wages to obtain qualified benefits.

DCAP. The dependent care assistance program.

Dependent. A dependent, as defined in the group medical coverage document.

Employee. Any person employed by the sponsor on or after the effective date of this plan, except that it shall not include a self-employed individual as described in Section 401(c) of the Code or a 2 percent shareholder of an S Corporation as defined in Section 1372 of the Code. Employee does not include any of the following:

1. Any employee included within a unit of employees covered under a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this plan;
2. Any employee who is a nonresident alien and receives no earned income from the sponsor from sources within the United States; and
3. Any employee who is a leased employee as defined in Section 414(n)(2) of the Code; and
4. Any person not classified by the sponsor as a common law employee and who is not placed on the sponsor's W-2 payroll.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Group medical coverage. The medical plan offered to employees as described in the group medical coverage document.

HSA. Health savings account.

Plan. The plan established by sponsor for its covered persons, as this plan currently exists or may be amended in the future. Each of the component plans described in this document are offered through the cafeteria plan.

Plan administration functions. Administration functions performed by sponsor on behalf of the plan (such as quality assurance, claims processing, auditing, and other similar functions). Plan administration functions do not include functions performed by sponsor in connection with any other benefit or benefit plan of sponsor.

Plan administrator. Medica.

Plan year. January 1 through December 31.

Qualified benefits. Benefits which are not subject to tax under certain sections of the Code and for which the covered employee has chosen to receive the benefit instead of wages or salary.

Qualified beneficiary. Any person who is, as of the day before a qualifying event, a participant in the medical FSA, the spouse of such a participant or the dependent of such a participant.

Qualified employee. An employee of sponsor who is scheduled to work on a regular basis at least twenty (20) hours per week. The sponsor may choose to administer eligibility through use of the federal look-back measurement period, and as a result a qualified employee will also include an employee throughout the applicable stability period, who is determined to have worked an average of at least thirty (30) hours per week based on the sponsor's look-back measurement period, which determination is made in accordance with federal law. The plan administrator determines an employee's status as a qualified employee.

Qualified event. Any of the following events which would otherwise cause a qualified beneficiary to lose coverage under the medical FSA:

1. The death of a participant covered under the medical FSA;
2. The termination (other than by reason of the participant's gross misconduct), or the reduction of hours of the employment of a participant covered under the medical FSA;
3. The divorce or legal separation of a participant covered under the medical FSA plan from the participant's spouse;
4. A participant covered under the medical FSA becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or
5. A dependent child ceasing to be a dependent child of a participant covered under the medical FSA under the generally applicable requirements of the plan.

Qualified high deductible health plan. A health plan that meets the requirements established in Code section 223.

QMCSO. A qualified medical child support order, as defined in ERISA § 609(a).

Sponsor. Medica.

Signature

IN WITNESS WHEREOF, the Benefits Manager of the sponsor has executed the foregoing plan on behalf of sponsor on this 20 day of April, 2023.

By: Michelle Benny

(please print)

Michelle Benny

(signature)

Its: Benefits Manager