North American Division of Seventh-day Adventists

Flexible Spending Account Plan

Summary Plan Description

Effective January 1, 2021

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INTRODUCTION

North American Division of Seventh-day Adventists has implemented a Section 125 Cafeteria Plan and a Flexible Spending Account Plan to enable you to purchase certain benefits on a pre-tax basis. The Flexible Spending Account Plan consists of two reimbursement accounts that are further described below.

The North American Division of Seventh-day Adventists Flexible Spending Account Plan is a church plan within the meaning of Internal Revenue Code Section 414(e) and Employee Retirement Income Security Act ("ERISA") Section 3(33). As a church plan, the plan is exempt from ERISA and is subject to the Church Plan Parity and Entanglement Prevention Act of 1999.

This Summary Plan Description is also the formal plan document for the North American Division of Seventh-day Adventists Flexible Spending Account Plan (the "FSA Plan"). The FSA Plan operates in conjunction with the North American Division of Seventh-day Adventists Section 125 Cafeteria Plan (the "NAD Section 125 Cafeteria Plan"), which is the plan that enables you to use pre-tax salary deferrals to pay for certain benefits, such as your health plan employee-share contributions (commonly referred to as premiums), and to set aside pre-tax dollars to pay for certain medical and dependent care expenses via the FSA Plan.

The FSA Plan is sponsored by the North American Division of Seventh-day Adventists. The "Participating Employers" in the FSA Plan are Seventh-day Adventist Organizations, inclusive of the General Conference of Seventh-day Adventists and its subsidiaries and affiliates based in the United States, that participate in this FSA Plan for the benefit of their respective eligible employees. For the purposes of both (i) the privacy obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and (ii) Plan financial liability, your Participating Employer is the plan sponsor for its piece of the FSA Plan. As such, any obligation to you as a Participant arising from this FSA Plan is a general asset obligation of your Participating Employer. The FSA Plan is subject to rules, regulations, and interpretations under the Internal Revenue Code.

DEFINITIONS

"ACA Full-Time Employee" means an Employee determined to meet the definition of a full-time employee under the Affordable Care Act by the Plan Administrator and pursuant to the definition of the terms of the Healthcare Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division Aka Ascend To Wholeness Healthcare Plans.

"Compensation" means the total cash remuneration received by the Participant by the Employer during a Coverage Period prior to any reductions pursuant to an enrollment authorized hereunder and prior to any salary reductions pursuant to Code Section 401(k), 403(b), 408(k), 457(b), 132(f), or 125, as applicable.

"Coverage Period" means the Plan Year during which a Participant elects to receive benefits under the FSA Plan, provided that, for any Employee who becomes a Participant after the start of a Plan Year, the initial Coverage Period shall mean the period commencing on the effective date of such Participant's participation and extending through the remainder of the Plan Year.

"Child" or "Children" means (1) a natural child; (2) a step-child (i.e., the child of an Employee's Spouse); (3) a child who has been legally adopted by the Employee or the Employee's Spouse, or placed for adoption with the Employee or the Employee's Spouse, by either a court of competent jurisdiction or appropriate state agency; (4) an individual for whom an Employee or the Employee's Spouse has been awarded legal guardianship by a court; and (5) an individual for whom the Employee is required to provide coverage pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO") as defined in applicable federal law originally enacted as part of the Child Support Performance and Incentives Act of 1998 [PL 105-200, 7/16/1998; Section 401(f)(1)].

"Dependent Care Account" means the bookkeeping account established for each Participant to reflect the transactions of the FSA Plan in providing Dependent Care Account benefits to Participants in accordance with this FSA Plan summary plan description, and in accordance with the NAD Section 125 Cafeteria Plan.

"Effective Date" of this amended and restated plan means January 1, 2021, or such later date as of which an adopting Participating Employer adopts the FSA Plan for its employees.

"Eligible Literature Evangelist" means a literature evangelist who meets the qualifications required by his or her Participating Employer according to North American Division Working Policy Section FP 70.

"Eligible Seminary Student" means a seminary student who meets the qualifications required by his or her participating employer.

"Employee" means an individual who is engaged by the Employer to perform services for the employer in a relationship that the Employer characterizes as an employment relationship. The following individuals are not employees:

- Individuals working for the Employer under a lease arrangement.

- Individuals who are engaged by the Employer to perform services for the employer in a relationship that the Employer characterizes as other than an employment relationship. For example, individuals engaged to perform services in a relationship which the Employer characterizes as that of an "independent contractor" with respect to the Employer.

- Any individual described in this definition as not an employee is not eligible to participate in the FSA Plan even if a determination is made by the Internal Revenue Service, the United States Department of Labor, another governmental agency, a court or other tribunal that the individual is an employee of the employer. An individual who has not met the definition of employee shall become an employee eligible to participate in the FSA Plan (subject the individual's meeting all other eligibility requirements of the FSA Plan) effective on the date the employer characterizes the individual as an employee in the Employer's employment records.

"Employer" means the Participating Employer at which you work.

"Flexible Spending Account" means the bookkeeping account established for each Participant to reflect the transactions of the FSA Plan and may consist of either or both a Medical Reimbursement Account and a Dependent Care Account maintained pursuant to this FSA Plan and in accordance with the NAD Section 125 Cafeteria Plan.

"FSA Plan" or "Plan" means the North American Division of Seventh-day Adventists Flexible Spending Account Plan.

"Full-Time Employee" means an Employee who is classified by his or her Employer as a full-time, exempt or non-exempt, regular Employee either working in his or her position or on an approved leave of absence. A Full-Time Employee also includes regular Employees working for two or more Participating Employers whose total number of hours equals or exceeds the number of hours per week required to be considered full time. (Such Employees will enroll through one Participating Employer, but the Participating Employers will share any Employer costs.) The final determination of whether an Employee is a Full-Time Employee under the terms of the Plan will be made by the Plan Administrator.

"Medical Reimbursement Account" means the bookkeeping account established for each Participant to reflect the transactions of the FSA Plan in providing Medical Reimbursement Account benefits to Participants in accordance with this FSA Plan summary plan description, and in accordance with the NAD Section 125 Cafeteria Plan.

"Participant" means an eligible Employee of a Participating Employer who is covered by this FSA Plan following acceptance by the Plan Administrator of that person's enrollment election. For new Employees, coverage is contingent upon enrolling within 30 days of the first day the Employee is eligible to participate in the FSA Plan (or a longer period if state law mandates such longer period for enrollment in the Employer's group health plan). For both new Employees and ongoing Employees, if you do not timely enroll in accordance with this SPD, you will be required to wait until the next open enrollment period unless you experience a change in status event and your new election satisfies the consistency rule.

"Participating Employer" means the Seventh-day Adventist Organizations, inclusive of the General Conference of Seventh-day Adventists and its subsidiaries and affiliates based in the United States, that participate in the Healthcare Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division Aka Ascend To Wholeness Healthcare Plans and who offer a Flexible Spending Account benefit to their Employees. All Participating Employers are required to be listed in the most recent version of the Adventist Organizational Directory or the most recent version of the Seventh-day Adventist Yearbook. Participating Employer entities are added and subtracted from time-to-time by amendment. If you are unsure as to whether your employer is a Participating Employer, please call the Plan Administrator at (888) 276-4732.

"Part-Time Employee" means an Employee who is not a Full-Time Employee. The final determination of whether an Employee is a Part-Time Employee will be made by the Plan Administrator.

"Plan" or "FSA Plan" means the North American Division of Seventh-day Adventists Flexible Spending Account Plan.

"Plan Administrator" means the North American Division of Seventh-day Adventists. The North American Division of Seventh-day Adventists shall have full discretionary power to administer the FSA Plan and to interpret, construe, and apply all of its provisions, determine eligibility, and adjudicate claims as provided herein. The Plan Administrator may delegate any of these duties as it deems reasonable and appropriate, and the Plan Administrator has determined that it will delegate its duties with respect to the FSA Plan to Adventist Risk Management. The Plan Administrator has also authorized Adventist Risk Management to delegate plan administrative duties to other entities. In administering the FSA Plan, the Plan Administrator and its delegates (including Adventist Risk Management and its delegates) shall be guided by and adhere to the teachings and tenets of the Seventh-day Adventist Church. When the term "Plan Administrator" is used in this Plan, it generally refers to Adventist Risk Management as the delegate of the North American Division of Seventh-day Adventists.

"Plan Sponsor" is the North American Division of Seventh-day Adventists; however, for the purposes of both (i) the privacy obligations under HIPAA, and (ii) Plan financial liability, your Participating Employer is the plan sponsor for its piece of the FSA Plan.

"Plan Year" means the twelve (12) month period commencing January 1 and ending December 31.

"Spouse" means your opposite sex lawful spouse under the applicable law of the state in which the Participating Employer facility at which you work is located (or if you are not assigned to a specific facility, then the state of Employer). Some states allow common law marriage, which is a legally recognized marriage that lacks formal marriage proceedings; "Spouse" does not include a spouse through common law marriage.

FLEXIBLE SPENDING ACCOUNTS

As benefit options under the NAD Section 125 Cafeteria Plan, the FSA Plan enables you to use pre-tax dollars to pay for many medical and dependent care expenses. There are two separate reimbursement accounts available to you that your pre-tax dollars will be deposited into if you so elect:

- Medical Reimbursement Account for qualifying medical, dental and vision expenses incurred by you and your eligible dependents; and

- Dependent Care Account for the costs of day care for your children or other eligible dependents.[1]

[1] If you are an Employee of the Rocky Mountain Conference of SDA, Campion Academy, Mile High Academy, the Idaho Conference of SDA, or Gem State Academy then you are not eligible for a Dependent Care Account.

Separate accounts will be maintained for each Participant and for each benefit the Participant elects of the options above. Special rules apply to the types of expenses eligible for reimbursement under each account. This booklet provides guidelines for using these accounts and lists some of the eligible expenses. If you have questions about Flexible Spending Accounts, contact the Plan Administrator at (888) 276-4732.

ELIGIBILITY

Any Employee who is eligible for the group health plan of the Employer (the Healthcare Assistance Plan for Employees of Seventh-day Adventist Organizations of the North American Division Aka Ascend To Wholeness Healthcare Plans) is eligible to participate in the FSA Plan. The following are eligible under the Ascend to Wholeness Healthcare Plans: Full-Time Employees, Eligible Literature Evangelists, Eligible Seminary Students, and any Employee of a Participating Employer not fitting within these categories who is an ACA Full-Time Employee (any Employee who is classified by his or her Participating Employer's human resources department as either temporary or per diem is not eligible to participate in the Ascend to Wholeness Healthcare Plans, unless determined to be an ACA Full-Time Employee). The determination of whether you are a Full-Time Employee, Part-Time Employee, or neither is usually determined initially by your Employer, but ultimately the Plan Administrator may make a different determination.

Each eligible Employee may elect to participate in the FSA Plan as of the beginning of the next following Plan Year Coverage Period. Any Employee whose employment begins after the beginning of a Plan Year Coverage Period may begin participation on the latter of (i) the date he/she submits his/her election enrollment paperwork, (ii) his/her first day of employment, and (iii) after completion of his/her Participating Employer's waiting period for group health plan coverage, if any. A newly hired Employee is required to submit his/her election enrollment paperwork within 30 days of the date he/she is first eligible for the FSA Plan (or a longer period if state law mandates such longer period for enrollment in the Employer's group health plan).

All elections under the FSA Plan are prospective only and shall only apply to Compensation that has not been actually or constructively received by the Participant as of the date of his/her election.

Annual Enrollment Period

An annual enrollment period will be scheduled by the Plan Administrator prior to the beginning of each Plan Year. At that time you will receive enrollment materials describing the Flexible Spending Accounts and the other options available to you under the FSA Plan.

If you decide to participate in one or both of the Flexible Spending Accounts, you must elect the total amount of your annual Compensation you wish to deposit into each account during the next Plan Year. The amount you elect to deposit into the appropriate Flexible Spending Account will be deducted pro rata from your pay beginning the first payday of the Plan Year. After an election is made, it may not be modified until the next annual enrollment period unless there is a Change in Status or other IRS authorized event that allows an election change.

If you do not submit a completed election, then you will be deemed to have elected taxable cash instead of Flexible Spending Account benefits. (A failure to elect Flexible Spending Account benefits will not impact your payment of employee-share contributions on a pre-tax basis under your Employer's health plan, which provides medical, dental, vision, and prescription drug benefits.)

Change in Status Events

Rules of the Internal Revenue Code require that generally, you may not change the amount you are depositing to your Flexible Spending Account Plan until the next annual enrollment period. However, you will be allowed to make a change if the change is a *Change in Status Event* and the *Consistency Rule* is satisfied. Valid *Change in Status Events* are events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under Internal Revenue Code Section 125, including the following:

For both Medical Reimbursement and Dependent Care Accounts:

- Change in Employee's Legal Marital Status (marriage, divorce, annulment, legal separation or death of Spouse).
- Change in Number of Dependents (events that change an employee's number of dependents, such as birth, adoption, placement for adoption or death).
- Change in Employment Status of Employee, Spouse or Dependent (any of the following that change the employment status of the Employee, the Employee's Spouse, or the Employee's dependent: termination or commencement of employment, strike or lockout, beginning or returning from an unpaid leave of absence, change in worksite, or a change from an eligible to an ineligible employment status or classification).
- Dependent Satisfies (or Ceases to Satisfy) Dependent Eligibility Requirements (events that cause an Employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as due to age, or other circumstances).

Other *Change in Status Events* may be allowed if they are acceptable under the Plan Administrator's interpretation of the Internal Revenue Code. If you have questions, please ask your Employer's benefits representative or the Plan Administrator.

If you experience a *Change in Status Event* and desire to make a change, you must make the change no later than 30 days following the *Event*.

Consistency Rule

A change must be "on account of and correspond with" a *Change in Status Event*. To meet this requirement, the change that you wish to make must be on account of and correspond with a *Change in Status Event* that affects eligibility for coverage under an employer's plan. This rule is satisfied as to the Dependent Care Account if the *Change in Status Event* affects expenses under that Account, such as when the Child becomes 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent

with" a *Change in Status Event* will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service. If you have questions, please ask your Employer's benefits representative or the Plan Administrator.

Other Events That May Allow Election Changes

- Cost Changes. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. If the caregiver is a relative, no change is permitted.

- Significant Coverage Change/Curtailment. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. It may apply, for example, when there is a change in provider, or eligibility for state-funded school resulting in decreased need for child care expenses.

- Change in Coverage of Spouse or Dependent Under Other Employer's Plan. This event applies to Dependent Care Accounts, but not to Medical Reimbursement Accounts. If there is a change in your, your Spouse's, or your dependent's coverage under another employer's plan, you may be allowed to change your election under the FSA Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

- Judgment, Decree, or Order. If a judgment, decree, or order (collectively called "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order requires an Employee to cover a Child under the Medical Reimbursement Account, the Employee may increase deposits to cover the Child. Likewise, if the order requires another individual to provide coverage for the Child and coverage is, in fact, provided, then the Employee may reduce deposits.

- Medicare and Medicaid. If an Employee, Spouse, or dependent becomes entitled to Medicare or Medicaid (other than coverage only for pediatric vaccines), the Employee may make a change to reduce deposits to the Medical Reimbursement Account to take into account Medicare or Medicaid. Likewise, if the Employee, Spouse, or dependent loses eligibility for coverage under Medicare or Medicaid, the employee may increase deposits to the Medical Reimbursement Account to take into account loss of that coverage.

Additionally, the Plan Administrator may modify your election(s) downward during the plan year if necessary to prevent the FSA Plan from becoming discriminatory within the meaning of the federal income tax law.

Special Election Change Rule for 2020 and 2021 Due to the COVID-19 Pandemic

Notwithstanding the foregoing, for the 2020 and 2021 Plan Years only, an Employee may prospectively change his/her Medical Reimbursement Account and/or Dependent Care Account elections at any time and for any reason, except that an Employee may not reduce his/her election for an account to below the amount already reimbursed from that account.

When Coverage Ends

A Participant will cease to be a Participant in this FSA Plan upon the earlier of:

(a) the termination of this Plan; or

(b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be eligible for participation in this FSA Plan.

When a Participant ceases to be a Participant under this FSA Plan, the Participant's salary reductions and prior elections will terminate and the Participant will not be able to receive reimbursements for expenses incurred after participation terminates. However, the Participant (or the Participant's estate as applicable) may file a claim for reimbursement for any eligible expenses incurred during the Coverage Period prior to termination in accordance with the appropriate procedures for submitting a claim.

HOW THE SPENDING ACCOUNTS WORK

You can use your Flexible Spending Accounts to pay for a variety of expenses related to medical care and dependent day care. You may participate in one account or both accounts, or you may decide not to participate at all.

The following describes the procedure:

- During the annual enrollment period you indicate the total amount you wish to deposit in each account during the coming year.

- The annual amount you elect will be divided evenly over the appropriate number of pay periods. Each pay period, an equal portion of the total amount will be deducted from your Compensation and credited to the appropriate account(s).

- When you incur eligible medical expenses, you use your Flexible Spending Account debit card and/or submit a reimbursement account claim form together with the original itemized bill or receipt or the explanation of benefits (EOB) form from your insurance carrier.

- In accordance with the Uniform Reimbursement Requirement for Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain reimbursement up to the amount you have elected to deposit into your Medical Reimbursement Account, even if that amount has not already been taken from your pay and deposited into your account.

- Reimbursements for dependent day care expenses are allowed up to the amount actually in your Dependent Care Account at the time you submit your request. If your claim exceeds the amount currently available in your Dependent Care Account, you receive additional reimbursements as more money is deposited into your account through payroll deductions.

- No interest will be credited to the Flexible Spending Accounts, funds may not be transferred between the accounts and any other accounts, and reimbursements will not be paid until after submission of eligible expenses.

TAX ADVANTAGES

The cash Compensation (wages) you receive from your Employer is taxable. However, when you allocate a portion of your Compensation on a pre-tax basis to be used for payment of your benefits, your taxable income is reduced by the amount you have allocated to benefits. This allocation results in a reduction of federal and, in most cases, state income taxes.

You do not have to pay taxes on the money you receive as reimbursement of eligible medical or dependent care expenses from the FSA Plan.

Social Security/Other Benefits May Be Affected

Since you do not pay Social Security taxes on any Compensation you deposit to your Medical Reimbursement Account or your Dependent Care Account, your future Social Security benefit could be slightly reduced. Although this reduction usually is quite small, it could occur if your Compensation falls below the annual Social Security taxable wage base as revised each year. The resulting decrease in your taxable Compensation could impact other benefits which may be available through your Employer.

MEDICAL REIMBURSEMENT ACCOUNT

You can deposit between $0.00 and $2,750.00[2] of your Compensation into your Medical Reimbursement Account each year. (This amount may increase slightly if indexed by the IRS for a cost-of-living adjustment before the Plan Year begins.) You can use the money in your account to reimburse yourself for any eligible medical expense for yourself or your dependents which has not been paid by any other benefit plan. For purposes of the Medical Reimbursement Account, eligible dependents include your Spouse, your Children who are age 26 or under at the end of the calendar year, and any other person who is your dependent for federal tax purposes (or could have been your dependent except that he/she filed a joint return, had a disqualifying amount of gross income, or you (or your spouse if filing jointly) could be claimed as a dependent on someone else's tax return).

Eligible Medical Expenses

Eligible medical expenses include most expenses that qualify as medical expenses under the Internal Revenue Code (see IRS Publication 502). A partial listing of eligible expenses includes the following; items marked with an asterisk (*) may require additional documentation or reimbursement may be limited to the difference between a normal item and a special need item:

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[2] If you are an Employee of the Rocky Mountain Conference of SDA , Campion Academy, or Mile High Academy then you are limited to a maximum of $1,000.

Deductibles & Co-Payments

Dental Expenses:
- *Routine & Preventive Services*
- *X-Rays*
- *Orthodontia & Appliances*
- *Restorative & Major services including fillings, crowns, implants, bridges*
- *Dentures*
- *Periodontal Services*

Vision Care Expenses:
- *Exam (Optometrist or Ophthalmologist)*
- *Rx Glasses & Contact Lenses & Supplies*
- *Corrective Surgery (RK & Lasik)*

Prescription Drugs including prescription vitamins and birth control pills

Medical Equipment:
- *Wheelchairs or Lifts*
- *Crutches*
- *Oxygen Equipment & Supplies*
- *Air Purifier/Filters**
- *Special Beds or Mattresses**
- *Blood Pressure Monitor*
- *Glucose Monitor*

Diabetic Supplies including test strips and Insulin

Hearing Expenses including testing and hearing aids plus batteries and repairs

Counseling & Psychiatric Treatment:
- *Psychiatrists & Psychotherapists*
- *Psychologists*
- *Legal fees related to commitment of mentally ill person*
- *Excluded: marriage/family counseling*

Therapy:
- *Treatment for Alcoholism or Drug/Chemical Dependency*
- *Physical Therapy*
- *Speech Therapy*
- *Prescription Smoking Cessation*
- *Prescription Weight Loss program*

Physical Examinations:
- *School & Work Physicals*
- *Annual Physical Exam including pap smears, mammograms and prostate screening*

Assistance for Disabled Persons:

- *Braille or other special books/items or cost of specially equipping home or car for access by disabled person**
- *Guide animals (purchase & care)*
- *Special Alert Systems*

Fees & Services:
- *Physicians, Surgeons, Anesthesiologists, OB/Gyn, or other specialists*
- *Ambulance (Air & Ground)*
- *Nursing (including room & board)*
- *Fertility Treatment*
- *Sterilization & Reversals*
- *Legal Abortion*
- *Medically necessary cosmetic services (e.g., following accident or mastectomy, etc.)*
- *Chiropractic services*

Alternative/Holistic Services: medically necessary treatment by licensed or certified practitioners including acupuncture and massage therapy

Other:
- *Medical Records*
- *Travel necessary to seek medical treatment (limitations apply)*
- *Organ/Tissue Donation Expenses*
- *Special Diet**
- *Support Garments* & Wigs*
- *Orthotics*
- *Prosthesis, Artificial Limbs*
- *Orthopedic shoes**
- *Shipping & Handling charges**
- *Disability testing & consultations*
- *Over-the-counter medication (such as aspirin), medical supplies (such as bandages and thermometers), and menstrual products*

If you use the Medical Reimbursement Account to pay for a particular medical expense, *you cannot claim the same expense as a deduction on your income tax return.*

The costs for a medicine or a drug will be eligible for reimbursement whether or not the medicine or drug requires a prescription or is available without a prescription (an "over-the-counter" medicine or drug).

If you receive a reimbursement from your Medical Reimbursement Account and reimbursement for the same expense through your medical or dental coverage or another health care plan, you must refund the reimbursement you received from your Medical Reimbursement Account to the FSA Plan.

Medical Expenses Not Eligible for Reimbursement

Not all medical expenses are eligible for reimbursement from your Medical Reimbursement Account. Here are some examples of expenses which are not eligible for reimbursement:

- Cosmetic Expenditures that are not medically necessary (e.g., teeth whitening, dermabrasion, chemical peels or spider vein treatment)

- General Wellness expenses (e.g., health club dues, special foods and supplements, vitamins, exercise programs and equipment, or weight loss programs), but see IRS Publication 502 for limited exceptions

- Insurance Premiums or Employee-Share Contributions (e.g., the amount you pay for coverage under your Employer health plan, replacement insurance for contact lenses, or other health plan policies)

- Other: Missed Appointment, Late Payment or Interest Charges

Submitting a Claim

You will be given a debit card with which you may make medical purchases and pay medical providers. Save all your receipts and documentation because, after using your debit card, the claims administrator may ask you for additional information to substantiate that the transaction was for a medical expense eligible for reimbursement.

When you do not use your debit card, you can submit a claim for an eligible medical expense at any time during the Plan Year. Obtain a Request For Medical Reimbursement form from the claims administrator, your Employer's benefits representative or the Plan Administrator and attach a copy of the original itemized bill or receipt for an expense not covered under your medical, dental, or vision coverage, or the explanation of benefits from the insurance carrier. Reimbursements will be made at least monthly. On the form you will confirm that the expense will not be reimbursed under any other health plan coverage.

The money you deposit in your account for the Plan Year will be used to reimburse you for eligible expenses incurred in that year only. You incur an expense when the service is provided, and not when the bill is sent or payment is made. For example, as a general rule, if the Plan Year is the calendar year, and you had a physical exam in 2012 and paid for it in 2013, you cannot submit a claim for the cost to your 2013 Medical Reimbursement Account. You can continue to submit claims for eligible medical expenses incurred during the Plan Year until March 30 following the end of the Plan Year.

You are eligible to carry over to the next Plan Year up to $550.00[3] remaining in your account as of the deadline for submitting claims. The funds carried over may be used to pay for eligible medical expenses incurred in the subsequent Plan Year only. If available, reimbursements will be made first from unused amounts credited for the current Plan Year, and, only after exhausting those current Plan Year amounts, then reimbursed from unused amounts carried over from the preceding Plan Year.

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[3] This amount may increase slightly if indexed by the IRS for a cost-of-living adjustment before the Plan Year begins.

Unused Balances

As a general rule, if you have any money left in your account at the end of the year, and you have not submitted claims for that money by the March 30 deadline, then you may carryover up to $550[4] of the remainder as discussed above. Any unused balance above the $550[5] carryover maximum will be forfeited.

All forfeitures from Plan participants will be used by the Participating Employer to offset any losses it has incurred for benefit payments under the Medical Reimbursement Account Plan and/or to reduce costs of administering the FSA Plan. After this, forfeitures may be used in any manner authorized by relevant law.

Please contact your Employer's benefits representative or the Plan Administrator if you have further questions about what happens to your unused balance at the end of a Plan Year.

Qualified Reservist Distributions

You may request a Qualified Reservist Distribution of any unused balance in your Medical Reimbursement Account.

A Qualified Reservist Distribution is a distribution of all or a portion of your Medical Reimbursement Account if:

- You were ordered or called to active duty for a period in excess of 179 days or for an indefinite period; and
- The distribution is made during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made for the plan year you receive your order or call.

DEPENDENT CARE ACCOUNT[6]

You can deposit between $0.00 and $5,000.00 of your Compensation into your Dependent Care Account each year. (If you are married, and your Spouse files a separate tax return, you can deposit only up to $2,500.) You can use the money in your account to reimburse yourself for dependent care costs which you incur so that you and your Spouse (if any) can work. If you are married but your Spouse does not work, he or she may be considered working during any month that he or she is a full-time student or is incapable of caring for himself or herself.

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[4] This amount may increase slightly if indexed by the IRS for a cost-of-living adjustment before the Plan Year begins.

[5] This amount may increase slightly if indexed by the IRS for a cost-of-living adjustment before the Plan Year begins.

[6] If you are an Employee of the Rocky Mountain Conference of SDA, Campion Academy, Mile High Academy, the Idaho Conference of SDA, or Gem State Academy then you are not eligible for a Dependent Care Account.

Special Rule

There are additional limits on the amount you can deposit to this account. The amount of your deposit cannot be greater than your income or your spouse's, whichever is lower. For example, if you earn $15,000 a year and your spouse earns $4,500, the maximum you can deposit for dependent care expenses is $4,500.

Under this special rule, if your spouse is a full-time student or is incapable of caring for himself or herself, he or she is assumed to have a monthly income of $250 if you have one eligible dependent, or $500 if you have two or more eligible dependents.

Eligible Dependent Care Expenses

You can use your Dependent Care Account to pay for dependent care expenses, as defined in Internal Revenue Code Section 129, for qualifying individuals. A qualifying individual is defined in the Internal Revenue Code and is summarized below:

- a child under age 13 (but see the "Special Rule for Age 13 Dependent Children Due to the COVID-19 Pandemic" section) whom you are entitled to claim as a dependent on your federal tax return (except in the case of divorced, separated, or living apart parents, the child will be treated as a qualifying individual of the parent who has custody for more than half of the calendar year and shall not be treated as a qualifying individual of the other parent); and/or

- Your spouse who isn't physically or mentally able to care for himself or herself and lives with you for more than half the year; and/or

- A qualifying relative (e.g., your child age 13 or older, your parent, or your spouse's parent) who isn't physically or mentally able to care for himself or herself, who lives with you for more than half of the year, and for whom you provide over one-half of his/her support.

Eligible dependent care expenses may include expenses for:

- care at dependent care centers that meet all applicable state and local requirements and provide care for more than six individuals;

- nursery school, preschool, or a similar program for children below the level of kindergarten;

- day camps (not overnight camps);

- services from individuals (other than certain relatives/dependents described below) who provide care inside or outside your home (except that to include services provided outside of your home for a qualifying individual age 13 or older, the qualifying individual must regularly spend at least eight hours a day in your home);

- services of a housekeeper, maid, cook or similar employee, for that portion of the time which is related to the care of a qualified individual.

The caregiver may be a relative as long as he or she is not your spouse, is not the parent of your child under age 13, is not your Child under 19 years old, and is not someone you (or your spouse if filing jointly) can claim as a dependent on your federal tax return. Expenses or fees related to attending kindergarten or a higher grade of education cannot be reimbursed. Other expenses not listed above that are authorized by the Internal Revenue Code may be reimbursed.

Tax Credit Versus Dependent Care Account

The federal government allows you to take a tax credit on your federal income tax return for qualified dependent care expenses. The difference between the Dependent Care Account and the tax credit is that the Dependent Care Account provides a reduction of your taxable income, while the tax credit offers a direct reduction of the amount of tax you pay.

Your individual financial circumstances will determine which method is best for you. You might wish to consult with a tax consultant or financial advisor before making a decision.

Submitting a Claim

You can submit a claim for an eligible dependent care expense at any time during the Plan Year. Obtain a No Wait Dependent Care Reimbursement form from the claims administrator, your benefits representative, or the Plan Administrator and attach the original itemized bill or receipt from the provider of services, showing the provider's Social Security number (or tax identification number), the dates of service and the amount. Reimbursement for eligible expenses will be processed within 24 hours after receipt of the claim.

The money you deposit in your account for the Plan Year will be used to reimburse you for eligible expenses incurred in that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. You can continue to submit claims for eligible dependent care expenses incurred during the Plan Year until March 30 following the end of the Plan Year.

Unused Balances

If you have any money left in your account at the end of the year, and you have not submitted claims for that money by the March 30 deadline, you will forfeit your unused balance. There is no carryover of amounts remaining in Dependent Care Accounts (except see the "Special Rule for Age 13 Dependent Children Due to the COVID-19 Pandemic" section below).

All forfeitures from FSA Plan participants will be used by the employer to reduce costs of administering the FSA Plan or may be used in any manner authorized by relevant law.

Special Rule for Age 13 Dependent Children Due to the COVID-19 Pandemic

Notwithstanding the above, if your Child turned age 13 in the 2020 Plan Year, then you may nevertheless be reimbursed for eligible dependent care expenses incurred on behalf of that Child during the remainder of the 2020 Plan Year (even though the Child was age 13 when the expenses were incurred). Additionally, if you have an unused Dependent Care Account balance at the end of 2020, you may seek reimbursement from that balance for expenses incurred during

the 2021 Plan Year on behalf of the Child who turned age 13 in 2020 until the Child reaches age 14.

CHANGES TO EMPLOYEE'S STATUS

If your employment status changes, participation in each of the reimbursement accounts may be affected. The effects of certain changes are described below.

Medical Reimbursement Account

Your participation in the Medical Reimbursement Account would be affected as follows, based on the type of employment change involved.

- **Leave of absence under the FMLA.** Your deposits may continue for as long as you are on paid leave or, if the leave is unpaid, you may elect to continue under the Medical Reimbursement Account and make deposits in a manner approved by your Employer. You should discuss payment methods with your Employer if you are on unpaid leave. If you wish, you can elect to cease making deposits while you are on FMLA leave. If you cease making deposits, you will not be considered a Participant in the FSA Plan, and you will not receive reimbursement for expenses incurred during the time you were not a Participant. When you return from FMLA leave, you can be reinstated in your account. If any generally applicable changes were made to the FSA Plan while you were out, those changes will also apply to you.

  Upon return from an FMLA leave during which coverage terminated, the Employer may require reinstatement into the FSA Plan Medical Reimbursement Account, provided that Employees on a non-FMLA leave are also required to be reinstated into the Medical Reimbursement Account. Upon reinstatement, whether or not required, the Employee may not retroactively elect Medical Reimbursement Account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing salary reduction payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing salary reduction payments in the same amount as in effect before the leave. For example, if an Employee has elected $1,200 of annual coverage under a Medical Reimbursement Account ($100 pre-tax funding monthly) and is on an FMLA leave during April, May, and June, during which coverage ceases, Employee on return from the leave in July may resume coverage at $1,200 by paying $150 per month from July through December. Alternatively, the Employee may resume coverage at the reduced level of $900 annually by paying $100 per month from July through December.

- **Non-FMLA Leave of Absence.** If your Employer's policies provide for a paid leave of absence that is not covered by the FMLA, your deposits continue as long as your salary continues. If your leave of absence is unpaid, you may have a permissible *Change in Status Event* that would allow you to discontinue your deposits and cease participation. Please refer to the section on "*Change in Status Events*." If you want to continue deposits even though you have had a *Change in Status*, those deposits would be made with after tax income. Upon return from a non-FMLA leave during which coverage terminated, the Employer may require

reinstatement the FSA Plan Medical Reimbursement Account. Upon reinstatement, whether or not required, the Employee may not retroactively elect spending account coverage for claims incurred during the period when the coverage was terminated. The Employee may resume coverage at the level in effect prior to the beginning of the leave, thus increasing salary reduction payments upon return from the leave or, alternatively, the Employee may elect to resume coverage at a reduced level, continuing salary reduction payments in the same amount as in effect before the leave.

- **Death.** In the event of your death, your deposits stop. However, your surviving dependents may submit for reimbursement, eligible expenses incurred prior to your death. Claims for eligible expenses incurred prior to your death must be submitted by March 30 following the close of the Plan Year.

- **Change to ineligible employment status.** Your deposits stop. However, you can continue to request reimbursement of eligible expenses incurred through the date of the employment status change. Claims must be submitted by March 30 following the close of the Plan Year.

- **Termination of employment.** Your deposits stop with the last paycheck you receive after termination. However, you may continue to request reimbursement of eligible expenses incurred through your termination date. Claims must be submitted by March 30 following the close of the Plan Year.

Dependent Care Account

A change in employment status would affect your participation in the Dependent Care Account generally the same way as listed above for the Medical Reimbursement Account with the following exception:

Leave of Absence: If you take any leave of absence, you can cease your deposits only if the leave of absence also qualifies as a *Change in Status Event*. A leave of absence qualifies as a *Change in Status Event* only if it is unpaid. Please remember that an eligible dependent care expense is one that allows you and your Spouse to work. If you or your Spouse are not working, dependent care expenses incurred during that time may not be expenses that are properly reimbursable. For this reason, you may want to consider timely ceasing deposits if you take an unpaid leave of absence. If you choose to continue deposits, those deposits would be made on an after-tax basis.

MORE IMPORTANT FACTS ABOUT THE REIMBURSEMENT ACCOUNTS

The Plan is administered by the North American Division of Seventh-day Adventists and its delegates (including Adventist Risk Management). Claims are administered by Flores & Associates, LLC, P.O. Box 31397, Charlotte, NC 28231-1397 (the "Claims Administrator"), which can be reached at 800-726-9982.

Plan Names

The North American Division of Seventh-day Adventists Section 125 Cafeteria Plan and the North American Division of Seventh-day Adventists Flexible Spending Account Plan. The

North American Division of Seventh-day Adventists Flexible Spending Account Plan contains two component accounts: Medical Reimbursement Accounts and Dependent Care Accounts.

Plan Documents

The North American Division of Seventh-day Adventists' cafeteria and flexible spending plans are fully described in (i) the North American Division of Seventh-day Adventists Section 125 Cafeteria Plan document and (ii) this Summary Plan Description which is the plan document for the North American Division of Seventh-day Adventists Flexible Spending Account Plan. If there is any conflict or inconsistency between this Summary Plan Description for the North American Division of Seventh-day Adventists Flexible Spending Account Plan and the North American Division of Seventh-day Adventists Section 125 Cafeteria Plan document, then the North American Division of Seventh-day Adventists Section 125 Cafeteria Plan document governs. If you have any questions about the Plans or if you would like to examine North American Division of Seventh-day Adventists Section 125 Cafeteria Plan document, contact the Plan Administrator at (888) 276-4732. It is intended that the Plans will be administered in accordance with all relevant statutory and governmental authority. To the extent that any Plan provision is contrary to any statutory and governmental authority, such authority will govern operation of the Plans.

Effective Date

January 1, 2021

Plan Sponsor/Plan Administrator

The FSA Plan is sponsored by the North American Division of Seventh-day Adventists. For the purposes of both (i) the privacy obligations under HIPAA, and (ii) Plan financial liability, your Participating Employer is the plan sponsor for its piece of the FSA Plan. As such, any obligation to you as a Participant arising from this FSA Plan is a general asset obligation of your Participating Employer.

The FSA Plan is administered by the North American Division of Seventh-day Adventists, which has delegated its plan administrative duties to Adventist Risk Management:

Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904
(888) 276-4732

The Plan Administrator has the discretionary authority to administer the Plan in all of its details, including determining eligibility for benefits and construing all terms of the plan. The Plan Administrator has the discretion to determine all questions of fact and/or law that may arise in connection with the administration of the Plan. The Plan Administrator may assign its duties to others, and the Plan Administrator has assigned its duties to Adventist Risk Management and has granted Adventist Risk Management the authority to delegate its plan administrative duties to other entities on its behalf. The function of claims administration, in accordance with the terms of the Plan documentation, has been assigned to the Claims Administrator.

Claims Administrator

Flores & Associates, LLC
P.O. Box 31397
Charlotte, NC 28231-1397
(704) 335-8211

Legal Service

The agent for service of legal process for the North American Division of Seventh-day Adventists Flexible Spending Account Plan is:

Adventist Risk Management
Plan Administrator
12501 Old Columbia Pike
Silver Spring, MD 20904

Any legal action arising out of this FSA Plan must be filed in Montgomery County in the State of Maryland.

Plan Number

501

Plan Year

The Plan year begins on January 1 and ends on December 31.

Type of Plan

The Medical Reimbursement Account is a type of welfare plan that reimburses eligible medical expenses that are not reimbursed from other sources. The Dependent Care Account is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Section 125 Cafeteria Plan is authorized by Section 125 of the Internal Revenue Code and allows payment for certain benefits on a pre-tax basis.

Sources of Contributions

Employees contribute to the plan through pre-tax dollars that are elected by the employee and authorized by the Section 125 Cafeteria Plan. Employees select the amount of their contributions, up to authorized limits.

Benefit Payments

Benefits to a Participant are paid from the Participant's Participating Employer's general assets. There is no independent source of funds or any insurance contract that guarantees the payment of benefits. For administrative convenience, the Claims Administrator processes all claims for reimbursements on behalf of the Participating Employers.

Insurance and Plans of Benefits

This FSA Plan shall not affect the benefits provided through the Employer's health plan or any contract of insurance. The plan administrator of your Employer's health plan and/or any insurance company shall continue to have exclusive authority and discretion to interpret plan/policy terms and to manage and control any funds held to the extent permitted under the terms of the plan/policy. This FSA Plan shall not affect the terms of any other programs of benefits, whether insured or self-funded.

Examination of Records

The Plan Administrator shall make available to each Participant such records as they pertain to the Participant, for examination at reasonable times during normal business hours.

Qualified Medical Child Support Orders

If required by any Qualified Medical Child Support Order ("QMCSO"), as defined in applicable federal law originally enacted as part of the Child Support Performance and Incentives Act of 1998 [PL 105-200, 7/16/1998; Section 401(f)(1)], the Plan will extend benefits to a Participant's non-custodial child. Participants and beneficiaries can obtain from the Plan Administrator, without charge, a copy of procedures used for determining whether an order satisfies the requirements for a QMCSO.

Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Limitation on Participant Rights

Nothing appearing in or done pursuant to the FSA Plan shall be held or construed:

(a) to give any person any legal or equitable right against any Participating Employer, the North American Division of Seventh-day Adventists, or Adventist Risk Management except as expressly provided herein or provided by law; or

(b) to create a contract of employment with any Participant, to obligate a Participating Employer to continue the service of any participating Employee or to affect or modify his or her terms of employment in any way.

Governing Law

This FSA Plan is governed by the Internal Revenue Code and the regulations issued thereunder, to the extent that the Code addresses a provision provided in the Plan. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not addressed

by the Code or otherwise preempted by federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Maryland.

Severability

If any provision of the FSA Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the FSA Plan, and the FSA Plan shall be construed and enforced as if such provision had not been included herein.

Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan or in any way shall affect the Plan or the construction of any provision thereof.

Amendment and Termination

North American Division of Seventh-day Adventists intends to continue the FSA Plan indefinitely. However, it reserves the right to change or to terminate the FSA Plan, or to eliminate any benefit under the FSA Plan, at any time without the consent of any Participant or dependent. North American Division of Seventh-day Adventists or its delegate, Adventist Risk Management, or any authorized officer or representative of the North American Division of Seventh-day Adventists or its delegate, Adventist Risk Management, can make changes to or terminate the Plan. You will be notified if any material changes are made.

CLAIMS DECISIONS AND APPEALING A DENIED CLAIM

The following information is provided regarding claims and review procedures for this Plan. It is based upon regulations issued by the U.S. Department of Labor. Claims for benefits under the Ascend to Wholeness Healthcare Plans are regulated separately by the claims and appeals procedure stated in therein.

Claims Decisions. Within 30 days after receipt of a claim, the Plan will make reimbursement for expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied. The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such

material or information is necessary, (4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process. In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial within 180 days after receipt of written notice of the denial. Your written request should be sent to the Claims Administrator, which will forward your request for review to the Plan Administrator. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil action in court. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing for a review of the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant 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 claim. If an internal rule, guideline, protocol, or other similar criteria was relied

upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to file a lawsuit.

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding. The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

Notwithstanding the foregoing, any claim which arises under your Employer's health plan, any other employee health plan or insurance contract(s), or any other benefit plan that is not a Flexible Spending Account covered by this FSA Plan shall not be subject to review under this FSA Plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A. Governing Law

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing and successor regulations restrict the Plan Sponsor's ability to use and disclose individually identifiable health information that is protected by HIPAA (hereafter "protected health information" or "PHI"). In this HIPAA section of the FSA Plan, the term "Plan Sponsor" refers to your Participating Employer. The following HIPAA definition of PHI applies to this Plan.

B. Protected Health Information

Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted herein or as otherwise required or permitted by HIPAA.

C. Provision of Protected Health Information to Plan Sponsor

(1) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan.

(2) Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that: (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a group health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(3) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in subparagraph C.(5) below and obtaining written certification as further described below in Section D. below, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan and having to do with payment and health care operations, including but not limited to activities such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

(4) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

(5) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

(i) 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 information 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 information infeasible.

(j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

Further, Plan Sponsor agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware. For this purpose, "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

(6) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow access to PHI only as designated by the Plan Sponsor, and only for plan administration purposes. Only the following employees or classes of employees or other persons under the control of the Plan Sponsor will be given access to PHI: (i) Officers of the North American Division of Seventh-day Adventists and Officers of its delegate, Adventist Risk Management, (ii) Employees of the North American Division of Seventh-day Adventists and Employees of its delegate, Adventist Risk Management, and (iii) Plan Sponsor's designated Benefit Coordinator and Controlling Committee. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures or other special discipline procedure that may be created by the Privacy Officer.

Further, Plan Sponsor will ensure that the above provisions related to Adequate Separation are supported by reasonable and appropriate security measures to the extent that the designees above have access to electronic PHI.

D. Certification of Plan Sponsor

The FSA Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in subparagraph C.(5) above, "Conditions of Disclosure for Plan Administration Purposes."

ADOPTION AGREEMENT FOR THE
NORTH AMERICAN DIVISION OF SEVENTH-DAY ADVENTISTS
FLEXIBLE SPENDING ACCOUNT PLAN

The authorized representative of Adventist Risk Management, in its role as delegate of the North American Division of Seventh-day Adventists, whose name appears below hereby adopts this North American Division of Seventh-day Adventists Flexible Spending Account Plan (the FSA Plan) on behalf of the Seventh-day Adventist Organizations, inclusive of the General Conference of Seventh-day Adventists and its subsidiaries and affiliates based in the United States, who have elected to be the Participating Employers for this FSA Plan on the _____ day of _____, _____, to be effective January 1, 2021.

ATTEST: (SEAL)

Adventist Risk Management, delegate of the North American Division of Seventh-day Adventists

By:_____
Name: Tim Northrop
Title: President/CEO of Adventist Risk Management