Flexible Benefits Plan Document
For

Chickasaw County

Effective January 1st, 2014

Restated July 1, 2022

CLAIMS ADMINISTRATOR

EMPLOYEE BENEFIT SYSTEMS
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ARTICLE I

INTRODUCTION

1.1 Purpose of the Plan. This document constitutes the IRC Section 125 Flexible Benefits Plan for the Employer named in the Adoption Agreement, which is attached hereto and incorporated by this reference. The purpose of the Plan (hereinafter called the Plan) is to permit employees of the Employer to choose various benefits from a menu of choices to best satisfy the individual needs of each employee. Benefits will be offered on a pre-tax basis under Section 105(b) of the Code.

1.2 Effective Date. The Plan is effective as of the date shown in Item 1.2 of the Adoption Agreement.

1.3 Plan Administration, Plan-Year. The Plan is administered by the employer on the basis of a plan year (the "plan year") as identified in Item 1.3 of the Adoption Agreement.

1.4 Benefit Programs. As of the effective date, the Plan includes various benefit programs, which have been established by the Employer as set forth in item 1.4 of the Adoption Agreement. The terms and conditions of the benefit programs are described in an applicable supplement attached to and forming a part of the Plan. Certain benefits under this Plan may be under other employee welfare benefit plans established from time to time by the Employer, which employee welfare benefit plans shall, to the extent permitted by law, supplement and form a part of this Plan. Notwithstanding the foregoing, benefits under deferred compensation arrangements shall not be offered under the Plan unless such arrangements include a qualified cash or deferred arrangement as defined in Section 401(k)(2) of the Code.

1.5 Grace Period. The FSA and DCAP benefits may include up to a two and a half month grace period to incur expenses for the plan year if selected in item 1.5 of the Adoption Agreement. A plan year that ends on June 30 would allow expenses to be incurred up to September 15 of the next plan year.

1.6 Legal Status. This Plan is intended to qualify as a cafeteria plan under Code §125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

1.7 Non-discrimination. The Health Care Flexible Spending Account shall not discriminate in favor of “highly compensated individuals” as to eligibility to participate or benefits available. The Health Care Flexible Spending Account shall be operated consistently with Code Section 105(h), regulations promulgated thereunder, and guidance issued by the Department of Labor or the Internal Revenue Service relating to discrimination testing.

The Dependent Care Flexible Spending Account shall not discriminate in favor of “highly compensated employees” or more than 5 percent owners of a company. The Dependent Care Flexible Spending Account shall be operated consistently with Code

Section 129, regulations promulgated thereunder, and guidance issued by the Department of Labor or the Internal Revenue Service relating to discrimination testing.

DEFINITIONS

Defined terms shall be capitalized in this Plan. As used in this Plan Document, the following terms shall have the following meanings:

"Account(s)" means the Benefit Accounts described in Section 4.1.

"Benefits" means the various Benefits offered under the Plan as outlined in the Adoption Agreement.

"Cafeteria Plan" means the 125 Cafeteria Plan offered by the Employer.

"Change in Status" as defined in Section 3.4.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Contributions" means the amount contributed to pay for the cost of the Benefits.

"Compensation" means the wages paid to an Employee by the Employer as reported in Box 1 of Form W-2, but adding back any wages forgone by virtue of any election for Salary Reduction under this Plan, any other cafeteria plan, and any compensation reduction under any Code § 132(f)(4) plan; but determined after salary deferral elections under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement.

"Dependent" means an individual you claim as a dependent on your Federal income tax and who is not a dependent of any other taxpayer. See IRS Publication 969 – Health Savings Accounts and Other Tax Favored Health Plans for additional information.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other compensation, but only if such amounts are includible in gross income for the taxable year.

"Effective Date" as defined in Section 1.2 of the Adoption Agreement.

"Electronic Protected Health Information" has the meaning described in 45 C.F.R. § 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means an Employee, as defined in section 2.1 below, who has met the Eligibility requirements of the Plan set out in Section 2.1 of the Adoption Agreement.

"Employee" means an individual employed by the Employer who is on the Employer's W-2 payroll, excluding independent contractors, temporary or casual employees, any self-employed individual, any partner in a partnership, and any more-than 2% shareholder by virtue of the Code Section 318 ownership attribution rules. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section 2.5.

"Employer" means Chickasaw County and its Affiliated Companies as identified in the Adoption Agreement.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

"FMLA" means the Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- The birth or adoption of a child or placement of a foster child in a participant's home;
- The care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- A participant's own serious health condition; or
- Any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

"Health FSA" means a Health Flexible Spending Arrangement.

"Health Savings Account (HSA)" means a Health Savings Account established under Code §223. This type of account is an individual trust or custodial account. It is established and maintained separately by an individual with a qualified trustee/custodian.

"Highly Compensated Employee (HCE)" means (for section 105 purposes) any Employee who is among the highest paid 25% of all employees, one of the highest paid

officers, or a shareholder who owns more than 10% of the value of the employer's stock.

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

"Key Employee" means any Employee defined as such in Code Section 416(I).

"Open Enrollment Period" means the month preceding the beginning of a Plan Year or other such period as may be prescribed by the Administrator.

"Participant" means an eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

"Period of Coverage" means the Plan Year. The following exceptions may apply: (a) for Employees who are newly eligible to participate (Section 2.1), it shall mean the portion of the Plan Year following their entry date; (b) for Employees who terminate participation (Section 2.2), it shall mean the portion of the Plan Year prior to their participation termination date. A different Period of Coverage may be established by the Plan Administrator and communicated to the Participants.

"Plan" means the Chickasaw County Flexible Benefits Plan as described herein and in any applicable Adoption Agreement, and which is intended for the exclusive benefit of Eligible Employees, and as may be amended from time to time.

"Plan Year" means the 12-consecutive month period beginning on July 1 and ending on June 30, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Salary Reduction" means the amount by which the Participant's compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e. Pre-tax basis).

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law and who is treated as a spouse under the Code. Notwithstanding the above, for purposes of the DCAP Component, the term Spouse shall not include (a) an individual legally separated from the Participant under a divorce decree or separate maintenance decree, or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"SPD" means the separate Summary Plan Description describing the terms of the Plan.

"Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)" means the Federal law covering the rights of participants who have a qualified uniformed services leave.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

ARTICLE II
PARTICIPATION

2.1 Eligibility. Employees of the Employer listed in Item 2.1 of the Adoption Agreement are eligible to participate in the Plan. Each employee of the Employer who has met the eligibility requirements shown in Item 2.1 of the Adoption Agreement will be eligible to participate in the Plan on the first entry date as set out in Item 2.1 of the Adoption Agreement after the employee has filed with the plan administrator any written agreement electing to participate in the Plan as is required by the plan administrator, on a form satisfactory to the plan administrator. Employees may not include any self-employed individual, a 2% or more S corporation shareholder, a sole proprietor, a partner, member of a limited liability company and any member of the board of directors that serves the Employer solely in that capacity.

The following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

2.2 Period of Coverage, Termination of Participation. A participant's period of Plan coverage with respect to any benefit under the Plan shall be the plan year (or the remaining portion of the plan year in which the participant first becomes eligible to participate in the Plan -- this is known as a "short plan year"). The plan year runs for a twelve-month period. The benefits for any participant or covered dependent will terminate on the first to occur of the following dates:

(a) The day the participant ceases to qualify as a participant as a result of termination of employment or failure to make the required contributions, if any;

(b) The day the participant terminates membership in a group or class of employees eligible for benefits;

(c) With respect to a covered dependent, the date such dependent ceases to be a dependent;

(d) The date a specific coverage or benefit is discontinued;

(e) The date the plan is terminated; or

(f) Your participation will end at the end of the expiration of the Period of Coverage if you file a false or fraudulent claim for benefits.

The Medical and Dental Insurance Benefits will terminate as of the date(s) specified in the Medical and Dental Insurance Plans. Reimbursements from the Health FSA and DCAP Accounts after termination of participation will be made pursuant to Section 4.7 for Health FSA Benefits and DCAP Benefits.

If an employee is rehired within the same Plan Year and is eligible to participate in the Plan, the employee may make new elections, provided that the employee is rehired more than 30 days after the employee has terminated employment. If the employee is rehired within 30 days or less during the same Plan Year, the employee's prior elections will be reinstated.

2.3 New Hire Enrollment. As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any salary reduction contributions from your pay.

The elections you make will remain in effect until the next plan year, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will have no coverage for the remainder of the plan year.

2.4 Spouses and Dependents. Spouses and dependents of eligible employees may not be independent participants in the Plan. However, spouses and dependents may be eligible to receive benefits offered under the Plan.

A dependent is defined by the Code, rules and regulations and will vary depending on the specific benefit in the Plan.

The Internal Revenue Service Notice 2010-38 provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Retroactively to March 30, 2010, both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid (or reimbursed) to the employee for such coverage

are excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

2.5 Former Employees. Former employees may be permitted to participate in the Plan by the Employer, provided, however, that the Plan is not predominately maintained for the benefit of former employees.

2.6 Special Participation Rules Relating to Health Savings Accounts. In no event shall an employee or eligible dependent of an employee be permitted to participate in this Plan if the fact of such participation will result in the employee or eligible dependent being treated as not an eligible individual for purposes of making contributions to a health savings account (HSA), provided the employee or eligible dependent has established or is planning to establish a HSA. Employee shall be required to affirmatively state on the Plan's election form that employee, employee's spouse or employee's eligible dependents participation in this Plan will not cause the parties' ineligibility for the HSA.

2.7 Michelle's Law. Michelle's Law provides that a group health plan may not terminate the coverage of a dependent child who is covered as a full-time student at a post-secondary educational institution as a result of that individual ceasing to meet the definition of full-time student due to a medically necessary leave of absence (or other change of enrollment, if medically necessary). In such a situation, the Plan is required to continue the individual's coverage for up to a year while he/she is on a medically necessary leave of absence unless coverage would otherwise terminate sooner under the terms of the Plan. The individual has to be a full-time student until the first day of the leave and must be medically certified by a treating physician. The treating physician must certify that the student's medical leave of absence or change in enrollment is medically necessary.

Michelle's Law amends ERISA. It applies to any group health plan subject to ERISA, which includes both fully-insured and self-funded plans. Michelle's Law did not amend Code section 152. Therefore reimbursements for eligible expenses of dependents under Michelle's law that do not meet the definition of dependent under Code 152 may be subject to tax.

The following FSA plans are not subject to Michelle's Law:

a. Plans that have less than two participants who are current employees as of the first day of the Plan Year;

b. Plans that provide coverage (reimbursements) for benefits that are limited to dental, vision, and long-term care benefits that are not an integral part of a group health plan; or

c. The employer offers other group health plan coverage (that is not just dental, vision, or long-term care coverage) and the maximum benefit

payable to a participant under the Health FSA is less than or equal to $500.00.

ARTICLE III
CONTRIBUTIONS

3.1 Employer Contributions. The Employer may pay some or all of the costs of the Plan at such times and in such amounts as shall be determined from time-to-time by the Employer from its general assets. Nothing herein shall require the Employer to segregate or set aside any funds or other property for the purpose of paying any amounts under the Plan.

3.2 Participant Contributions. An Employee-Participant may elect, in writing on a form prepared by, and filed with, the Plan Administrator on or before the date he first becomes eligible, to participate in the Plan, and on or before the first day of any Plan Year thereafter, to reduce his compensation for such Plan Year and to contribute the amount of such salary reduction to the Plan as his required contribution under the Plan. Pursuant to such written election form, the participant shall also apportion his salary reduction contributions among the benefits provided for in the Plan for which the participant or his covered dependents qualify. In no event shall the sum of the amounts apportioned by the participant to each benefit exceed the total amount of his salary reduction contribution. Salary reduction contributions will be made through payments made periodically corresponding to payroll withholding payments beginning with the first regularly scheduled payday for the plan year for which the participant's written election is made (or the first regularly scheduled payday which is on or after the date the participant first becomes eligible to participate in the plan if a salary reduction agreement has previously been properly executed). Severance pay and paid time off pay may be used to make Participant contributions.

The Plan Administrator will establish rules and regulations with respect to salary reduction agreements hereunder in accordance with applicable law and regulations issued by the Department of the Treasury under IRC Section 125 of the Code. Participant contributions shall be used to provide plan benefits under the Plan or to pay premiums to modified or fully self-funded programs, insurance companies, health maintenance organizations or other organizations or institutions to provide such benefits as soon as reasonably practical, but in no event later than 90 days after such contributions are made. A participant's salary reduction contributions which are not used to provide plan benefits for such plan year as provided in the preceding sentence shall not at any time be returned or repaid to participants but shall be forfeited.

3.3 Annual Open Enrollment. Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. You must make a new election each year to participate in the Flexible Spending Accounts. Current year elections will not automatically continue in the new plan year. The elections you make will take effect on the first of the plan year and stay in effect through the end of the plan year, unless you have a qualifying change in status.

3.4 Changes or Discontinuance of Participant Contributions. A participant may not revise the rate of his salary reduction contributions or discontinue making salary reduction contributions except as follows:

(a) The participants may file a written election form with the Plan Administrator on or before the end of any plan year revising the rate of their contributions or discontinuing such contributions effective as of the first regularly scheduled payday of the next following plan year.

(b) The participant's contributions will automatically terminate as of the date his plan participation terminates in accordance with Section 2.2 above.

(c) The participant may file a written mid-year election change form with the Plan Administrator to revoke any prior election and to make a new election with respect to the remaining portion of a plan year on account of, and consistent with an Event that allows an exception to the Irrevocability Rule. The new election must be made within thirty (30) days of the family status change and be effective as of the date it is approved by the Plan Administrator. Exceptions to the Irrevocability Rule would include the following events:

1. FMLA (Family Medical Leave Act) as described in Article IX.

2. Change in status as described below including any changes to Code § 125 or regulations issued there under.
   - Change in marital status (such as marriage, death of a spouse, divorce, annulment, or legal separation).
   - Change in number of dependents (such as a birth of a child, adoption or placement for adoption, or death of a dependent).
   - An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement (such as a specific age, full-time student status).
   - A change in the Participant's, Participant's Spouse's or Participant's Dependent's place of residence that affects eligibility in the network service area.
   - Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent and that affects benefit eligibility under this or any other plan of your spouse or dependent. Such events include termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly paid, fulltime to part-time (or vice versa); incurring a reduction or increase in hours or any other similar change which; makes the individual become (or cease to be) eligible for a particular benefit.

3. Gains in coverage eligibility under another employer's plan. (Excludes FSA changes)

4. Certain judgments, decrees and orders.

5. Medicare or Medicaid.

6. Change in cost such as a significant change in premium. (Excludes FSA changes)

7. Change in coverage such as a significant curtailment of coverage, addition or significant improvement of plan option, loss of other group coverage, change in election under another employer plan, or DCAP coverage changes. (Excludes FSA changes)

8. Change in the participant, participant's spouse or participant's dependent ceases to be eligible for Medicaid or SCHIP coverage or becomes newly eligible for premium assistance under Medicaid or SCHIP. For purposes of these events only, the new election must be made within sixty (60) days of the termination of coverage or eligibility for premium assistance.

You may prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage (that is not a health FSA) if the following conditions are met:

- You have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result you ceasing to be eligible for coverage under the Plan; and
- You represent that the revocation of the election of coverage under the Plan corresponds to your intended enrollment, and the intended enrollment of any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

You may prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage (that is not a health FSA) if the following conditions are met:

- You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

You represent that the revocation of the election of coverage under the group health plan corresponds to your intended enrollment, and the intended enrollment of any related individuals who cease coverage due to the revocation, in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

For purposes of this Section, any election by a plan participant to change the apportionment of his/her salary reduction contributions among the various benefits provided for in the Plan will be considered a revision of the rate of his contributions.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory.

3.5 Special Rules regarding HSA Benefit Elections. If the employer offers the ability to make HSA contributions through the Plan, employees may make prospective salary reduction elections or change or revoke an election at any time during the plan year. Such mid-year election must be applied only to salary not yet currently available to the employee, and shall be effective as of the first of the month following the month in which the election is made.

ARTICLE IV
PARTICIPANTS' ACCOUNTS, BENEFIT CLAIMS, PAYMENT OF BENEFITS

4.1 Participant's Benefit Accounts. For the purpose of providing participants with the choice of which one or more of the benefits under the Plan are to be provided to the participant, the Plan Administrator shall establish with respect to each participant a bookkeeping account to reflect each benefit elected by the participant (all such accounts are sometimes collectively referred to herein as the "benefit accounts" and individually as a "benefit account").

For purposes of adjusting participant's benefit accounts to reflect participant's salary reduction contributions and distributions of plan benefits, benefit accounts shall be described as "premium payment benefit accounts" (if the applicable benefit is a premium payment benefit) or "reimbursement benefit accounts" (if the applicable benefit is a reimbursement benefit or direct payment benefit). Immediately following the payroll processing date (or the date the participant first becomes eligible to participate), the Plan Administrator will credit the appropriate reimbursement benefit accounts of participants electing reimbursement benefits under the Plan with the total amount apportioned by the participant on his salary reduction agreement to provide such reimbursement benefit to the participant or, if applicable, his covered dependents for such plan year. As of each regularly scheduled payday, or such other day as provided by the Employer, the Plan Administrator will credit the appropriate premium payment benefit accounts of participants making salary reduction contributions with the portion of each participant's salary reduction contribution which such participant previously designated to be apportioned to provide such premium payment benefit to the participant or, if applicable, his covered dependents.

The participant's premium payment benefit account or reimbursement benefit account shall be charged by the Plan Administrator when the amounts allocated to such accounts are applied to provide benefits. In the event that benefit payments charged to any benefit account exceed the balance of such account, the employer shall be responsible for paying the full amount of the vouchered and verified expense as long as the request does not exceed the total benefit allocated for that account for that plan year. No interest shall be credited on participants' account balances. Any positive balance in a participant's benefit account on the last day of any plan year, which is not used to provide benefits incurred during such Plan Year, shall be forfeited by the participant. The Employer will not be liable if an insurance company fails to pay for any of the insured benefits.

Any unclaimed (un-cashed) benefit payments by the close of the Plan Year following the Period of Coverage in which the Medical/Dependent Care Expense was incurred shall be forfeited back to the Employer.

4.2 Submitting a Claim for Reimbursement. You may submit a claim form to the Claims Administrator to request reimbursement of incurred expenses. The Claims Administrator may utilize forms and require documentation of costs or other evidence as may be necessary to verify the claims submitted. All claims must include the name of the person on whose behalf the claim has been incurred, the nature and date of the incurred expense, a statement that the expense has not otherwise been reimbursed, and such other information required to process the claim, such as bills, invoices, or other similar documentation.

Expenses are incurred at the time the service is received, not when the care or service is billed, charged, or paid. All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized. Reimbursement payments shall be payable to you.

If an expense is determined to not be an “eligible expense” you will receive notification of this determination. If you are denied a benefit under the Health Care FSA or Dependent Care FSA, you may file an appeal.

The Claims Administrator will provide a summary with each reimbursement that shows the amount reimbursed and your current balance. You can also request information about your account balance by contacting the Claims Administrator.

4.3 Payment of Benefits. Benefits payable under the Plan for, or on behalf of, a participant or covered dependent shall be paid as soon as practicable in such amounts, at such times and to such persons as shall be determined in accordance with the Plan. The form and manner of payment shall comply with the terms and conditions of the Plan. Benefits may be paid directly from the general assets of the Employer. All or a portion of the benefits provided under the Plan may be paid directly to the person or institution on whose charges a claim is based.

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable

from the Participant's gross income for federal, state or local income tax purposes. It is the responsibility of the Participant to determine whether each payment under this Plan is excludable from their gross income for federal, state and local income tax purposes. The Participant must notify the Plan Administrator if he/she believes that such payment is not so excludable.

If a Participant receives payment or reimbursement under this Plan on a tax-free basis and such payments do not qualify for such treatment under the Code, then the Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes or other such taxes from such payments or reimbursements.

4.4 Payment of Benefits to Others. Each participant or covered dependent from time to time may name any person (who may be named concurrently, contingently, or successively) to whom the participant's or covered dependent's benefits under the Plan are to be paid if the participant or covered dependent dies before he receives all such benefits. Each such beneficiary designation will revoke all prior designations by the participant or covered dependent; shall not require the consent of any previously named beneficiary; shall be in a form prescribed by the Plan Administrator; and will be effective only when filed with the Plan Administrator during the participant's or covered dependent's lifetime.

If a participant or covered dependent fails to designate a beneficiary before his death, as provided above, or if the designated beneficiary dies before the date of the participant's or covered dependent's benefits, the Plan Administrator, in its discretion, may pay such benefits to either (a) one or more of the participant's or covered dependent's relatives by blood, adoption, or marriage and in such proportions as the plan administrator determines, or (b) the legal representative or representatives of the estate of the last to die of the participant or the covered dependent and his designated beneficiary. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

4.5 Facility of Payment. When a person entitled to benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his affairs, the Plan Administrator may direct the payment of benefits to such person's legal representative, or to a relative or friend of such person for such person's benefit; or the Plan Administrator may direct the application of such benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with the preceding sentence shall be a full and complete discharge of any liability for such payment under the plan.

4.6 Use of Debit Card. The Employer may elect, as part of the Adoption Agreement, to provide for debit cards to be used by a participant to pay for or to reimburse a participant for medical and dependent care expenses.

When you receive your card, read the terms and conditions found on the card insert, then sign the back of your card. If you choose to activate your card, you will need to call the

toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will then be ready to use.

Your card may be used at any approved provider or merchant with a point-of-service (POS) bankcard terminal. Examples of qualified locations and providers include: hospitals, physician and dental offices, vision care providers, retail pharmacies, as well as many child and adult day care facilities.

In order to use your card, follow the instructions included with your card. It can be used at any POS bankcard terminal, just as if you were purchasing an item using a credit card. Your Flexible Spending Account and debit card are regulated by the IRS, therefore it is your responsibility to retain all itemized receipts. If a payment must be verified, the Plan Administration also may request this receipt from you to ensure that payment was made for a qualified expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

A transaction that includes non-eligible items or services will be denied completely, even though a portion of the transaction may be eligible. If you are purchasing non-eligible expenses at a location, you will need to purchase these items in a separate transaction.

Your card can be used for co-payments, deductibles, and coinsurance at many physician locations. However, the card does not determine any patient responsibility or eligible benefits.

When you use your card at a POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your Expense Accounts based on the guidelines established by the IRS and the terms of the Plan.

For questions about using your card, or to report a lost or stolen card or request additional cards, contact the Claims Administrator.

4.7 Reimbursements after Termination of Participation. When a participant ceases to be a participant under Section 2.1, the Participant's salary reductions and election to participate will terminate. He/She will not be able to receive reimbursements for Medical and Dependent Care Expenses incurred after the date the Participant's employment terminates or he/she ceases to be eligible to participate in the Plan. The Participant will have 90 days from the date that he/she is no longer eligible to submit claims for reimbursement of expenses incurred prior to the date of ineligibility.

A Participant and his/her Spouse and Dependents whose coverage terminates because of a COBRA qualifying event shall be given the opportunity to continue on a self-pay basis the same coverage that he/she had the day before the qualifying event as described by COBRA. Reference Article VIII of this Plan.

4.8 Procedure if Benefits Are Denied Under This Plan. If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan.

ARTICLE V
ADMINISTRATION

5.1 Administrative Information. The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- How to contact the Plan Administrator;
- How to contact the Claims Administrator;
- What to do if a benefit claim is denied; and
- Your rights under ERISA and other Federal laws such as COBRA.

5.2 Plan Sponsor and Administrator. Chickasaw County is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the address and telephone number listed in the Adoption Agreement.

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the "Named Fiduciary" for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan, correct defects, supply omissions, and reconcile inconsistencies in the Plan, ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of

credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

5.3 Information Required for Plan Administration. The records of the Employer as to an employee's or participant's period or periods of employment, termination of employment and reason therefore, leaves of absence, re-employment, and compensation will be conclusive on all persons. Participants and other persons entitled to benefits under the Plan also shall furnish the Plan Administrator with such evidence, data, or information, as the Plan Administrator considers necessary or desirable to perform its duties.

5.4 Decision of Plan Administrator Final. Subject to applicable law and the provisions of Section 5.5, any interpretation of the provisions of the Plan, and any decision on any matter within the discretion of the Plan Administrator, made by the Plan Administrator in good faith, shall be binding on all persons. A miss-statement or other mistake of facts shall be corrected when it becomes known and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable.

5.5 Review of Benefit Determinations. If a claim for benefits made by a participant or his beneficiary is denied, the Plan Administrator shall, within 90 days (or 180 days if special circumstances require an extension of time) after the claim is made, furnish the person making the claim with a written notice specifying the reasons for the denial. Such notice shall also refer to the pertinent plan provisions on which the denial is based, describe any additional material or information necessary for properly completing the claim and explain why such material or information is necessary, and explain the Plan's claim review procedures. If requested in writing, the Plan Administrator shall afford each claimant whose claim has been denied a full and fair review of the Plan Administrator's decision and, within 60 days (120 days if special circumstances require additional time) of the request for reconsideration of the denied claim, the Plan Administrator shall notify the claimant in writing of its final decision.

5.6 Coordination of Benefits with HSA. Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not previously been reimbursed and will not seek reimbursement elsewhere. The Health FSA shall not be considered a group health plan for coordination of benefits purposes. These benefits shall not be taken into account when determining benefits payable under any other plan.

Participants with contributions to their Health Savings Account (HSA) during the year may only elect a Limited Purpose FSA.

5.7 Uniform Rules. The Plan Administrator shall perform its duties on a reasonable and nondiscriminatory basis and shall apply uniform rules to all participants similarly situated based on prevailing IRS guidance.

5.8 Indemnity. To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator

against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

5.9 Mistakes and Errors. It is recognized that in the administration of the Plan certain mathematical and accounting errors may be made or mistakes may arise by reason of factual errors in information supplied to the Employer or the Sponsor. The Sponsor shall have power to cause such equitable adjustments to be made to correct for mathematical, accounting, or factual errors made in good faith, as the Sponsor in its discretion deems appropriate.

ARTICLE VI
FUNDING, AMENDMENT, AND TERMINATION OF THE PLAN

6.1 Funding. The Plan shall be maintained on an unfunded basis and benefits shall be paid solely as required out of the general assets of the Employer or under any contract issued by a modified or fully self-funded program, insurance company, health maintenance organization, or other organization or institution.

6.2 Future of the Plan. The Company expects that the Pan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

6.3 Termination. The Employer shall have the right at anytime to terminate this Plan, with a 30-day notice provided that such termination shall not eliminate any obligations of the Employer, which theretofore have arisen under the Plan. Upon termination, the grace period, or elected run out period – whichever applies, can be continued at the normal monthly fees.

6.4 Named Fiduciary. The Employer is the named fiduciary for purposes of ERISA § 402(a).

6.5 Expenses. All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the Company elects to pay such expenses.

ARTICLE VII
GENERAL PROVISIONS

7.1 Fraud. No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

7.2 No Obligation to Continue Employment. The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

7.3 Gender and Number. Words denoting the masculine gender shall include the feminine and neutral genders and the singular shall include the plural and plural shall include the singular wherever required by the context.

7.4 Limitation on Liability. It is expressly understood and agreed by each participant that, except for its or their willful misconduct or gross neglect, the Employer shall not in anyway be subject to any legal liability to any participant for any cause or reason or thing whatsoever in connection with this Plan, and each such participant hereby releases the Employer and its agents from any and all liability or obligation, except as in this section provided and except as provided by applicable federal law.

7.5 Participant Litigation. In any action or proceeding involving the Plan, or the administration thereof, employees or former employees of the Employer or any other person having or claiming to have an interest in this Plan shall not be necessary parties to such action or proceeding and shall not be entitled to any notice or process thereof except as required by applicable law. Any final judgment, which is not appealed or appealable, that may be entered in any such action or proceeding, shall be binding and conclusive upon the parties hereto and upon all persons having or claiming to have any interest in the Plan. To the extent permitted by law, if a legal action is begun against the Employer, or a modified or fully self-funded program, insurance company, health maintenance organization, or other organization or institution providing benefits under the Plan, by or on behalf of any person, and such action results adversely to such person; or, if a legal action arises because of conflicting benefit claims, the cost to the Employer, or such modified or fully funded program, insurance company, health maintenance organization or other organization or institution, of defending the action, will be charged to the sums, if any, which were involved in the action or were payable to the participant, covered dependent or person concerned. To the extent permitted by applicable law, election to become a participant under the Plan shall constitute a release of the Employer and its agents from any and all liability and obligation not involving willful misconduct or gross neglect.

7.6 Addresses, Notice, Waiver of Notice. Each participant must file with the Plan Administrator, in writing, his/her current mailing address. Any communication, statement, or notice addressed to such a person at his last post office address, as filed with the Plan

Administrator, will be binding upon such person for all purposes of the Plan, and the Employer shall not be obliged to search for or ascertain the whereabouts of any such person. Any notice required under the Plan may be waived by the person entitled to notice.

7.7 Data. Each participant or covered dependent must furnish the Employer such documents, evidence, or information as the Employer considers necessary or desirable for the purpose of administering the Plan or to protect the Employer or any modified or fully self-funded program, insurance company, health maintenance organization or other organization or institution providing benefits under the Plan. Evidence required of anyone under the Plan shall be signed, made or presented by the proper party or parties, and may be by certificate, affidavit, document or other information, which the person acting thereon considers pertinent and reliable.

7.8 Mistake of Fact. Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

7.9 Effect of Tax Regulations on this Plan. This Plan is designed and administered in accordance with Sections 125 and 129 of the Internal Revenue Code. These code sections enable you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the date you have a qualifying change in status as described in Section 3.4.

7.10 Severability. If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

7.11 Applicable Law. The Plan shall be construed according to ERISA and the Internal Revenue Code of 1986, as amended from time to time and as construed, interpreted and modified by regulations or rulings promulgated thereunder. The Plan is intended to constitute a cafeteria plan meeting the requirements of IRC Section 125 of the Code. The Plan shall be construed and enforced according to the laws of the State of Iowa to the extent not pre-empted by any federal law.

7.12 Cancellation of Coverage. If you fail to pay any required premium for coverage under the Plan, your coverage will be canceled, and no claims incurred after the effective date of cancellation will be paid.

7.13 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom payment is due because it cannot ascertain the identity or whereabouts of such Participant/other person after reasonable efforts

have been made to identify and locate such person, then the payment and all subsequent payments due to such person shall be forfeited.

7.14 Non-Alienation of Benefits. With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

7.15 Headings and Captions. The heading and captions used in the Plan are for convenience only.

7.16 Rescission of Coverage. Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the premiums paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you.

7.17 Coverage While Not at Work. In certain situations, coverage may continue when you are not at work, so long as you continue to pay your required contributions to the Plan. You should discuss with your supervisor what options are available for remitting your Flexible Spending Account contributions while you are absent from work.

7.18 Agent for Service of Legal Process. If any disputes arise under the Plan, papers may be served upon the Plan Administrator.

ARTICLE VIII
YOUR COBRA RIGHTS

8.1 Continuing Your Health Care FSA through COBRA. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice.

This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

If your coverage under the Health Care Flexible Spending Account ends due to a COBRA qualifying event, you will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA Continuation Coverage will be available to you only if you have a positive Health Care Expense balance at the time of the COBRA qualifying event (taking into account all claims submitted by you before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year (and any extended period) in which the qualifying event occurs and coverage will cease at the end of the Plan Year. Coverage will not be continued for the next Plan Year.

8.2 COBRA Notifications. If you lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

8.3 Cost of COBRA Coverage. You pay the full cost to continue participation in the Health Care Flexible Spending Account, plus an administrative fee of two percent, or 102 percent of the amount you authorized to contribute to the Health Care Flexible Spending Account.

8.4 COBRA Continuation Coverage Payments. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrolment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full payment is received. Each month's premium is due prior to the first day of the month of coverage. You are responsible for making timely payments.

If you fail to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

ARTICLE IX
GENERAL INFORMATION

9.1 FMLA. The Family Leave Act of 1993, regulated by the Department of Labor, allows certain election changes mid-year on account of leaves of absence. For an employer to be subject to the Family Medical Leave Act, there must be employed by the Employer *50 or more* active employees. An employee taking leave under the FMLA may continue or revoke an existing election of accident or health plan coverage including the Health Flexible Spending Account. If the employee elects to continue, the employee must also have the option of suspending payment for such coverage during the leave. If the employer continues coverage during an unpaid leave, the employer may recover the employee's share of the premiums when the employee returns to work. The employee has a right to be reinstated in the group health plan coverage upon returning from FMLA leave if such coverage terminated during the leave (either by revocation or due to non-payment of premiums). The reinstatement right includes being reinstated on the same terms as before the FMLA leave, subject to any changes in benefit levels. The employee's reinstatement right includes the right to revoke or change elections under the election changes regulations on the same terms as employees who are working and not on FMLA leave. An employee who elects to continue health coverage while on unpaid FMLA leave may do so in one of three ways: pre-pay, pay-as-you-go, and catch-up. If applicable, the Employer will provide detailed information upon the employee taking the FMLA leave.

9.2 Your Rights under ERISA. As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.

- 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the document governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. 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 court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your 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, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

9.3 QMCSO. This plan extends benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA 609(a). The plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Administrator.

9.4 NMHPA. The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

9.5 HEART. The Heroes Earnings Assistance and Relief Tax Act of 2008 (Heroes Act or HEART Act), amends the cafeteria plan rules to allow health FSAs to provide for qualified reservist distributions of all or a portion of the health FSA account balances of participants who are reservists called to active duty for 180 days or more (or for an indefinite period). Distributions may be made at any time from the date of the call to duty through the last date on which reimbursements may be made for the plan year in which the call occurred.

9.6 Uniformed Service Under USERRA. A Participant who is absent from employment on account of being in "uniformed service" as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. It is the responsibility of the Participant to make the required contributions during the USERRA Leave. Payments shall be made in the same manner as FMLA Leave as stated above in Section 9.1.

ARTICLE X
YOUR HIPAA RIGHTS

10.1 Health Insurance Portability and Accountability Act (HIPAA). Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provision" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans, including Health Care Flexible Spending Accounts. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- Enrollment of eligible individuals;
- Eligibility determinations;
- Payment for coverage;
- Claim payment activities;
- Coordination of benefits; and
- Claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provision to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

SUPPLEMENT: Group Medical Plan Coverage Premium Payment Benefits under 125 Flexible Benefits Plan

1. Purpose. The purpose of this Supplement is to permit participants to pay the employee portion of the cost of coverage under the Group Medical Plan by making salary reduction contributions to the Plan. This Supplement constitutes the group medical premium payment plan of the Employer. The benefit provided under this Supplement is a "premium payment benefit." The specific provisions of the Group Medical Plan, as set forth in a contract(s) or policy(s) issued by a company, shall be considered a part of the Plan and incorporated herein by reference.

2. Amount of Premium Payment Benefit. Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to reduce his compensation and to contribute the amount of such salary reduction to the Plan as his group medical premium cost. The term "group medical premium cost," as used in the Plan, means the participant's share of the cost of group medical coverage. A participant who fails to make the election shall be deemed to have made an automatic election to reduce his or her compensation by the premium amount selected under the Group Medical Plan election, and such election shall be deemed to be made on an annual basis thereafter unless a different election is made by the participant.

SUPPLEMENT: Dependent Child Care Reimbursement Plan Benefits under 125 Flexible Benefits Plan

1. Purpose. The purpose of this Supplement is to provide for the reimbursement of certain child and dependent care expenses to participants. This supplement constitutes the child and dependent expense reimbursement plan of the Employer. The benefit provided under this supplement is a "reimbursement benefit" called the Dependent Care Assistance Plan (DCAP).

2. Maximum Annual Amount. The maximum annual benefit amount that you may elect under the Dependent Care Flexible Spending Account for a Plan Year is the smallest of the following amounts: 1) $5,000 ($2,500 if you are married and filed your Federal tax return as Married – Filing Separately); or 2) the lesser of the calendar year earned income limitation for you or your spouse described in Section 129(b) of the Code. If your spouse is not employed and is either 1) physically or mentally incapable of self-care; or 2) a student during a month in which you incur a dependent care expense, Earned Income shall be the amount specified in Code Section 21(d)(2).

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

3. Child Care Tax Credit. The IRS allows you to claim work-related dependent care expenses for credit on your Federal income tax return. The tax credit is determined by applying a percentage to your total work-related dependent care expenses. You may use both a dependent care flexible spending account and the tax credit, provided you do not claim the same expenses for both. You must also adjust your tax credit by the amount you contribute to the Dependent Care Flexible Spending Account. For more information about the child care tax credit, see IRS Publication 503 or IRS Form 2441 and the accompanying instructions. You may also wish to consult with your tax advisor to determine which option is best for your particular tax situation.

4. Payment of Dependent Care Expense Account Claims. The maximum amount available for reimbursement at any time from a Dependent Care Expense Account shall be the lesser of:

- The amount of allowable dependent care expenses submitted for reimbursement; or
- The amount credited to the Participant's Dependent Care Expense Account at that time, reduced by previous reimbursements during the year.

Your Dependent Care Expense Account will be reduced by the amount of the reimbursement paid. Advance reimbursement shall not be made for projected or future expenses.

5. Non-duplication of Benefits. A participant shall not be reimbursed for child and dependent care costs under this Plan to the extent that such costs are paid to, or for the

benefit of, the participant, or to, or for the benefit of, any individual included in his family unit, under the provisions of any other Plan. Also, a participant must reduce on a dollar for dollar basis, any expenses excludable from gross income under this dependent child care option to the extent that those same dollars might be claimed under the Dependent Care tax credit (i.e. the same dollars cannot be claimed on both the taxpayer tax return and under this account.).

6. Eligible Dependent Care Expenses. You may use the Dependent Care FSA to pay certain dependent care expenses that are necessary to allow you – and your spouse, if you are married – to work or attend school full-time. The Plan will reimburse all employment-related expenses defined by Section 21(b)(2) of the Code, incurred by you on behalf of a qualifying dependent. These include payments to babysitters or companions inside or outside the home, licensed day care centers, as well as Federal and state taxes which you pay for providers of dependent care. For purpose of this Section, a qualifying dependent will be defined by Section 21(b)(1) of the Internal Revenue Code.

Reimbursement will be made upon your submission of documentation that such expenses were incurred to enable you to be gainfully employed for any period during which there was one or more qualifying dependents, provided however that:

- If such amounts are paid for expenses incurred outside your household, they shall constitute employment-related expenses only if incurred for a qualifying dependent under Section 21(b) of the code, who regularly spends at least 8 hours per day in your household;
- If the expense incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all state and local laws and regulations, including licensing requirements, if any; and
- Employment-related expenses for you do not include amounts paid or incurred to your child over the age of 19 or to an individual who is a dependent of you or your spouse.

NOTE: The Family Support Act of 1988 requires that you provide the name, address, and taxpayer identification number (or Social Security number) of your provider. You must include this information when you submit a claim for reimbursement.

The following expenses do not qualify for reimbursement:

- Transportation expenses to or from the day care center;
- Care provided by an individual who could be claimed as a dependent on your or your spouse's Federal tax return;
- Services which are eligible for reimbursement under any other plan or program;
- Clothing, education, or food, unless food and education are provided by the day care center or nursery school as part of its prescribed care services. Food and education expenses are not covered for kindergarten or higher;
- Tuition;
- Overnight camp expenses;
- Expenses for days when you are not working (such as sick or vacation days) or any other day when you do not meet the eligibility requirements.

A complete list of allowable dependent care expenses can be found in IRS Publication 503 Child and Dependent Care Expenses or on the IRS Web site at www.irs.gov.

If you have questions about what is considered an eligible expense under the Dependent Care Flexible Spending Account, contact the Claims Administrator.

7. Dependent Care Annual Amount. The participant will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Dependent Care Expenses they have incurred and the annual coverage level that was elected and paid for. The difference will be forfeited. The participant will forfeit any amount allocated to the Dependent Care Assistance Plan if that amount has not been applied to the Dependent Care Account for any Plan Year by the end of the 90 day run out period or grace period if applicable, following the end of the plan year for which the election was made.

SUPPLEMENT: General Purpose Flexible Un-Reimbursed Medical Expense Plan
Benefits under 125 Flexible Benefits Plan

1. Purpose. The purpose of this Supplement is to provide for the reimbursement of certain health expenses to participants. This Supplement constitutes the health expense reimbursement plan of the Employer. The benefit provided under this supplement is a "reimbursement benefit" called a Health Flexible Spending Account.

2. Amount of Benefit. Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to be reimbursed from the Employer for health care costs (as defined in paragraph 3) incurred, when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care, during that year with respect to him and to his family unit (as defined in paragraph 4) to the extent that such costs do not exceed an amount equal to the lesser of:

(a) The total health care costs paid by the participant and attributable to health services rendered during the plan year or, if elected by the Employer the grace period, must not extend beyond the fifteenth day of the third month following the close of the plan year and regardless of whether such costs are paid by the participant during such plan year; or

(b) The amount that the participant has elected to have withheld for the benefit for the Plan Year (limited by the **maximum reimbursement amount as determined by the Internal Revenue Service (IRS) for the current and subsequent years**).

3. Health Care Costs. . The term "health care costs," as used in the Plan, means amounts paid by a participant because of deductible amounts, copayment amounts, co-insurance provisions, exclusions from coverage, over the counter drugs, menstrual care products, or as a result of any other provision of the Employer's health care plan to the extent that such amount, if paid or reimbursed under such plans, would be excluded from the participant's taxable income. In no event shall health care costs include any item, which is not included within the meaning of "medical care" as defined in Section 213(d) of the Code of the participant and his family unit.

4. Family Unit. The term "family unit," as applied to any participant, means the participant, his spouse, and such of his eligible children as are dependents as defined by the IRS Code.

5. Manner of Making Payments. The Employer shall reimburse each participant for the portion of his family unit's health care costs that is payable to him under paragraph 2, provided that the plan administrator receives evidence acceptable to it that such health care costs have been incurred, (as defined in #2), by the participant or any other member

of the family unit and the Plan Administrator receives a signed statement from the participant that he has not, and will not in the future, deduct such costs as expenses on his individual Federal or State Income Tax Returns, and further provided that such expenses are documented by statements from an independent third party showing the date the medical expense was incurred, provider of said expense, patient, fee charged and amount due after insurance has paid, if any.

6. Non-duplication of Benefits. A participant shall not be reimbursed for health care costs under this Plan to the extent that such costs are paid to, or for the benefit of, the participant, or to, or for the benefit of, any individual included in his family unit, under the provisions of any other plan.

7. Eligible Medical Expenses. The Health Care Flexible Spending Account will pay only claims incurred during the year that are eligible for "Medical Expenses", as that term is defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. Over the Counter (OTC) drugs, sold lawfully without a prescription at a reasonable quantity, can be paid with pretax dollars and do not need to be run through insurance coverage to qualify for reimbursement. Some OTC drugs will be dual purpose, having a personal/cosmetic and/or general health purpose or a medical purpose. For these items, a mechanism must be used to determine whether the primary use of the item is medical care and will require a Medical Practitioner's note stating that the person has a specific medical condition and that the OTC drug is recommended to treat the condition and that the treatment is not a cosmetic procedure. Under the CARES ACT, menstrual care products are an eligible expense as of January 1, 2020. Menstrual care products are defined as tampons, pads, liners, cups, sponges, or similar products used by an individual with respect to menstruation.

It is the participant's responsibility to comply with Internal Revenue Code requiring taxpayers to maintain receipts and or payment verification for Health Care Spending Account reimbursements.

8. Flexible Spending Account Annual Amount. The participant must submit all claims for reimbursement by the end of the claims payment period immediately following the end of the plan year for which the election was made. The participant will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Flexible Spending Account Expenses that they have incurred and the annual coverage level that was elected and paid for. The participant will forfeit any amount allocated to the Flexible Spending Account if that amount has not been applied to the Flexible Spending Account for any Plan Year by the end of the 90 day run out period, or grace period if applicable, following the end of the plan year for which the election was made. However, if you are participating in the Health Care Flexible Spending Account on the last day of the Plan Year and you have an unused amount remaining in your FSA, if the employer elects to offer a carryover, up to $500 may be carried forward to be used in the following Plan Year. Carry forward amounts from the previous plan year may:

- Reduce your amount available to pay previous plan year expenses during the run-out period,

- Will be counted against the permitted carryover amount, and
- Cannot exceed the carryover amount.

SUPPLEMENT: Limited Purpose Flexible Unreimbursed Medical Expense Plan Benefits under 125 Flexible Benefits Plan

1. Purpose. The purpose of this Supplement is to provide for the reimbursement of certain health expenses to participants who also receive benefits under a health savings account ("HSA"). This Supplement constitutes a limited purpose health expense reimbursement plan of the Employer. The benefit provided under this supplement is a "reimbursement benefit" called a Health Flexible Spending Account, for the limited purpose of providing reimbursement for vision and dental expenses and preventative care benefits, as permitted under Revenue Ruling 2004-45 and Notice 2004-23, as may be amended, modified or superseded from time-to-time.

2. Amount of Benefit. Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to be reimbursed from the Employer for health care costs (as defined in paragraph 3) incurred, when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care, during that year with respect to him and to his family unit (as defined in paragraph 4) to the extent that such costs do not exceed an amount equal to the lesser of:

(a) The total health care costs paid by the participant and attributable to health services rendered during the plan year or, if elected by the Employer the grace period must not extend beyond the fifteenth day of the third month following the close of the plan year and regardless of whether such costs are paid by the participant during such plan year; or

(b) The amount that the participant has elected to have withheld for the benefit for the Plan Year (limited by the **maximum reimbursement amount as determined by the Internal Revenue Service (IRS) for the current and subsequent years**).

3. Health Care Costs. The term "health care costs," as used in the Plan, means amounts paid by a participant because of vision or dental expenses or preventative care expenses. In no event shall health care costs include any item, which is not included within the meaning of "medical care" as defined in Section 213(d) of the Code of the participant and his family unit.

4. Family Unit. The term "family unit," as applied to any participant, means the participant, his spouse, and such of his eligible children, as are dependents as defined by the IRS Code.

5. Manner of Making Payments. The Employer shall reimburse each participant for the portion of his family unit's health care costs that is payable to him under paragraph 2, provided that the plan administrator receives evidence acceptable to it that such health care costs have been incurred, (as defined in #2), by the participant or any other member

of the family unit and the Plan Administrator receives a signed statement from the participant that he has not, and will not in the future, deduct such costs as expenses on his individual Federal or State Income Tax Returns, and further provided that such expenses are documented by statements from an independent third party showing the date the medical expense was incurred, provider of said expense, patient, fee charged and amount due after insurance has paid, if any.

6. **Non-duplication of Benefits.** A participant shall not be reimbursed for health care costs under this Plan to the extent that such costs are paid to, or for the benefit of, the participant, or to, or for the benefit of, any individual included in his family unit, under the provisions of any other plan.

7. **Flexible Spending Account Annual Amount.** The participant must submit all claims for reimbursement by the end of the claims payment period immediately following the end of the plan year for which the election was made. The participant will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Flexible Spending Account Expenses that they have incurred and the annual coverage level that was elected and paid for. The participant will forfeit any amount allocated to the Flexible Spending Account if that amount has not been applied to the Flexible Spending Account for any Plan Year by the end of the 90 day run out period, or grace period if applicable, following the end of the plan year for which the election was made. However, if you are participating in the Health Care Flexible Spending Account on the last day of the Plan Year and you have an unused amount remaining in your FSA, if the employer elects to offer a carryover, up to $500 may be carried forward to be used in the following Plan Year. Carry forward amounts from the previous plan year may:

- Reduce your amount available to pay previous plan year expenses during the run-out period,
- Will be counted against the permitted carryover amount, and
- Cannot exceed the carryover amount.

SUPPLEMENT: AFLAC Insurance
Premium Payment Benefits under 125 Flexible Benefits Plan

1. Purpose. The purpose of this supplement is to permit participants to purchase for themselves and/or dependents coverage under the AFLAC Insurance Premium Plan by making salary reduction contributions to the plan. This Supplement constitutes the AFLAC Insurance Premium plan of the Employer. The benefit provided under the supplement is a "premium payment benefit". The specific provisions of the AFLAC Insurance Premium Plan, as set forth in a contract(s) or policy(s) issued by a company, shall be considered a part of the plan and incorporated herein by reference.

2. Amount of Premium Payment Benefit. Subject to the conditions and limitations of the Plan, each year each participant may elect, in writing on a form filed with the Plan Administrator on or before the date he first becomes eligible to participate in the Plan, and on or before the first day of any plan year thereafter, to reduce his compensation and to contribute the amount of such salary reduction to the Plan as his AFLAC Insurance Plan premiums cost. The term "AFLAC Insurance plan premium cost" as used in the Plan, means the participant's share of the cost of AFLAC Insurance coverage.

ADOPTION AGREEMENT
Flexible Benefits Plan
Sponsored by
Chickasaw County

Name and address of Employer(s):

Chickasaw County
8 East Prospect
PO Box 311
New Hampton, IA 50659

Name and address of Plan Administrator(s): Same as above

1.1 Employer Name: **Chickasaw County**

1.2 Original Effective Date: **January 1st, 2014**
Amended Date: **July 1, 2022**

1.3 Plan Year: **July 1 to June 30**

1.4 Benefit Programs Offered:

(X) Medical Plan Premiums*

( ) Dental Plan Premiums*

( ) Vision Plan Premiums*

( ) Group Term Life Plan Premiums (Employees Only)*

( ) Long Term Disability Income Plan Premiums*

( ) Short Term Disability Income Plan Premiums*

( ) Cancer Insurance Premiums*

(X) Dependent Child Care Reimbursement Plan

(X) General Purpose Flexible Un-Reimbursed Medical Expense Plan
Maximum Annual Contribution Amount: $2,850 or IRS maximum

(X) Limited Purpose Flexible Un-Reimbursed Medical Expense Plan
Maximum Annual Contribution Amount: $2,850 or IRS maximum

( ) Voluntary AD&D Plan*

( ) HSA Contributions

(X) AFLAC Insurance Premiums*

*It is the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

1.5 FSA Grace Period Election: **X** Apply 2½ month grace period
_____ Do not apply 2½ month grace period
DCAP Grace Period Election: **X** Apply 2½ month grace period
_____ Do not apply 2½ month grace period

2.1 Eligibility Requirements: An individual is eligible to participate in this Plan (including the Premium Payment Component, the Health FSA Component, the HSA Component, and the DCAP Component) on the first day of the month following 30 days of employment if the individual satisfies all of the following:

- Is a full-time active employee normally scheduled to work a minimum of 35 hours per week;
- Is on the regular payroll of the Company; and
- Is in a class of employees eligible for coverage

Eligibility for Premium Payment Benefits shall also be subject to the additional requirements, if any, specified in the Medical, Dental and Life Insurance Plans.

3.1 Employer Contributions:

X The Employer does not contribute to the health FSA

_____ The Employer allocates benefit dollars towards Employer Flex Credits into a health FSA ($1 for $1 match up to the $1,350 annual limit)

_____ The Employer allocates benefit dollars towards Employee taxable salary

_____ The Employer provides a Health Insurance Opt-Out/Waive allocation into the health FSA ($500 annual limit)

_____ The Employer provides a Health Insurance Opt-Out / Waive allocation towards Employee taxable salary

4.6 Debit Card Option **X** Use debit card option for FSA/DCAP
___ Do not use debit card option for FSA/DCAP

9.2 ERISA General Information:
Plan Name: **Chickasaw County**
Plan Sponsor: **Chickasaw County**
Plan Administrator: **Chickasaw County**
Address: **8 East Prospect, PO Box 311, New Hampton, IA 50659**

Employer Identification Number (EIN): **42-6005031**
Plan Funding and Type of Administration:

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	Employees make contributions to the Plan through payroll deduction. Assets of the Plan are used for the exclusive purpose of providing benefits to Plan participants and their beneficiaries. Any contributions will remain part of the general assets of the Company and benefits will be paid solely from those general assets.

The Plan Administrator has contracted with the following company to administer benefits and pay claims. You may contact the Claims Administrator directly, using the information listed below:

Employee Benefit Systems (EBS)
214 N. Main Street
P.O. Box 1053
Burlington, IA 52601
800-373-1327
www.ebs-tpa.com

10.10 Plan Sponsor HIPAA Employee Classifications for PHI Disclosures:
Chickasaw County

- Plan Sponsor may disclose PHI to its accountants, the third party administrator of the Plan, Insurance brokers or other entities providing quotes for future services to the Plan, other health plans that provide health benefits to a Participant for purposes of subrogation and coordination of benefits and all business associates of the Plan.

- The Plan Sponsor may provide PHI to the above names, individuals and entities to permit treatment, payment or health care operations under the Plan.

10.12 HIPAA Privacy Officer: Chickasaw County
Title: County Auditor
Address: 8 East Prospect, PO Box 311, New Hampton, IA 50659

ADOPTION OF THE PLAN

The Chickasaw County IRC Section 125 Flexible Benefits Plan, effective January 1st, 2014, as amended and restated herein, is hereby adopted as of July 1st, 2022. This document constitutes the basis for administration of the Plan. The Plan shall be construed according to the laws of the State of Iowa.

It is understood that full responsibility is assumed by the undersigned organization establishing the Plan, which organization acknowledges having counseled with its legal and tax advisors with respect to the adoption of the Plan and the selection of options.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this **_____ day of _____, 2022.**

Chickasaw County

_____

Authorized Signature *Title*