# DISCOVERY BENEFITS, LLC

# Unified School District 233 dba Olathe Public Schools Retiree Health Reimbursement Arrangement

## Summary Plan Description

**Effective January 1, 2021**

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## ABOUT THIS SUMMARY PLAN DESCRIPTION

This Summary Plan Description ("SPD") is comprised of the following two parts –

- This document that describes information about your plan coverage and other statements that are required by law; and
- An Adoption Agreement for the Discovery Benefits, LLC Retiree Health Reimbursement Arrangement that is attached to this document which references the type of plan and its terms that was adopted by your Employer and which contains addresses and phone numbers you can use to contact the Plan Administrator of your plan coverage.

If you do not have both parts of this SPD, contact your Employer.

The rules and operation of your group health plan are described in this SPD as clearly as possible with minimal use of the technical terms appearing in the official legal documents (including applicable insurance contracts). However, the official legal documents remain the final authority and, in the event of a conflict with this SPD, shall govern in all cases. You may request a copy of the official legal documents from the Plan Administrator.

This SPD may only be used when your Employer has contracted with Discovery Benefits to be the Claims Administrator of your Plan. Once Discovery Benefits is no longer the Claims Administrator, this document shall be void with respect to any term, condition or requirement of Discovery Benefits.

## ELIGIBILITY AND PARTICIPATION

### ELIGIBLE EMPLOYEES

This is a Retiree-Only HRA as listed in Section 3.1. of the Adoption Agreement, only retirees may participate in the HRA. The retiree eligible for this plan is listed in Section 2.1 of the Adoption Agreement.

### SPOUSE AND DEPENDENT COVERAGE

As a Plan participant you can receive reimbursement for eligible claims for your eligible spouse and eligible children, subject to any specific requirements or limitations listed in the Adoption Agreement. In addition, if elected in your Adoption Agreement, you can also receive reimbursement for eligible claims for any other eligible individual who qualifies as your Federal income tax dependent. You can receive reimbursement for eligible claims for a child who is covered by a qualified medical child support order (QMCSO). If your Plan covers children as set forth in the Adoption Agreement, then a child of a participant (e.g., biological, adopted, step and eligible foster children) shall be a dependent hereunder up to his or her 26$^{th}$ birthday.

Your eligible spouse includes your legal spouse to whom you are legally married under any applicable state or foreign jurisdiction (including same and opposite sex spouses). Common law spouses are also eligible, where applicable based on state or foreign law.

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the Plan, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

### COMMENCEMENT OF PARTICIPATION

If you are eligible for participation in the Plan, the effective date of your coverage will be the date listed in the Adoption Agreement. Your enrollment rights are also subject to any waiting periods that your Employer may impose. Any applicable waiting period is listed in the Adoption Agreement. All waiting periods are calculated using the elapsed time method.

### TERMINATION OF PARTICIPATION

Your Plan coverage will terminate at the time of death. Please review the Adoption Agreement for any additional forfeiture, contribution and claims filing rules upon death.

## BENEFITS

### REIMBURSEMENTS

The Plan allows you to be reimbursed for Qualifying Medical Expenses as set forth in the Adoption Agreement.

Retiree-Only HRA

With a Retiree-Only HRA as noted in Section 3.1. of the Adoption Agreement, you can be reimbursed for any Code Section 213(d) expense, including major medical individual insurance premiums, stand-along dental and vision premiums, Medicare Part B premiums, Medicare Advantage premiums, Medicare Part D premiums and Medicare supplemental insurance premiums (e.g., MediGap). However, you cannot be reimbursed for another employer group health plan premiums.

### CODE SECTION 213(D) EXPENSES

If your HRA includes reimbursements for any Code Section 213(d) expense, the IRS requires that the expense is:

- For the diagnosis, cure, mitigation, treatment or prevention of disease and for treatments affecting any part or function of the body, and
- Primarily to alleviate or prevent a physical or mental defect or illness.

Expenses NOT generally eligible for reimbursement are those:

- Solely for cosmetic reasons, or
- Merely beneficial to one's general health (for example, health spas, vacations)

You should review the section entitled "Reimbursements" very carefully to determine whether there are any restrictions or limitations on your Plan.

If you have any questions as to whether an expense satisfies the Code Section 213(d) requirements, please review the rules set forth on the Claims Administrator's website at www.discoverybenefits.com, or contact Participant Services at 1-866-451-3399 or via email at customerservice@discoverybenefits.com.

## SPECIAL REIMBURSEMENT RULES

The following includes other special rules regarding Plan reimbursements and benefits –

- Any expense submitted for reimbursement under the Plan cannot also be reimbursed or paid by any other health plan.

- Expenses incurred prior to the effective date of the Plan or before you began Plan participation are not eligible for reimbursement.

- Eligible expenses incurred for yourself may be reimbursed from the HRA Account. Expenses incurred for your spouse, your child or other dependent will only be reimbursed if your spouse, child or other dependent satisfies the provisions to be eligible for the Plan as set forth in the Adoption Agreement. Expenses for your domestic partner and your partner's dependent children are not eligible for reimbursement from your HRA Account, unless they are considered your tax dependents for federal income tax purposes and such individuals are otherwise eligible as set forth in the Adoption Agreement.

- Any money you don't use in a particular Plan Year will carry over to the following Plan Year, subject to any limitations set forth in the Adoption Agreement.

Participants may be provided with a debit card by the Claims Administrator to pay for Qualifying Medical Expenses. Any debit card shall be subject to the debit card's terms of use and any other requirements established by the Claims Administrator for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Claims Administrator shall apply correction procedures as set forth in guidance promulgated pursuant to Section 125 of the Internal Revenue Code.

If your debit card transaction is approved, you must retain your written receipts as the Claims Administrator is required to audit certain debit card transactions. If adequate written substantiation cannot be provided, the Claims Administrator will apply IRS required correction procedures, which may include you repaying the amount of the unsubstantiated transaction to the plan.

## MAXIMUM REIMBURSEMENTS

The amount that your Employer will credit to your HRA Account is set forth in the Adoption Agreement. Unused amounts from the prior calendar year may be carried forward to subsequent calendar years as set forth in the Adoption Agreement, and subject to any limitations in the Adoption Agreement. You may not be reimbursed for an amount of eligible expenses that is greater than your HRA Account balance

## REIMBURSEMENT REQUESTS

During the course of the calendar year, you may submit requests for reimbursement of expenses you have incurred. The Claims Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Claims Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter.

## CLAIM AND APPEALS

When you have a claim to submit for reimbursement, you must:

(1) Obtain a claim form from the Claim Administrator;

(2) Complete the Employee portion of the form; and

(3) Attach copies of all bills or receipts from the healthcare provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed.

Decisions will be made within a reasonable period of time appropriate to the circumstances but no later than the time periods set forth below. "Days" means calendar days.

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| Notification of whether claim is accepted or denied | 30 days |
| Extension due to matters beyond the control of the Plan | 15 days |
| Insufficient information on the claim: | |
| Notification of insufficient information | 15 days |
| Required Response by Participant | 45 days |

The Claim or Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Once an appeal is filed, the Claim Administrator or Plan Administrator will notify you within 60 days thereafter of whether the appeal is approved or denied.

A document, record, or other information shall be considered relevant to a claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) Constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

## AMENDMENT AND TERMINATION

Your Employer reserves the right to discontinue or terminate the Plan, or to reduce, amend or modify coverage in whole or in part and in any respect. The Claims Administrator also has the right to amend and revise certain provisions of the Plan. This may be done at any time and without advance notice. Benefits for claims occurring after the effective date of a modification or termination are payable in accordance with the revised provisions of the Plan.

All statements in this SPD and all representations by your Employer, the Claims Administrator and their personnel are subject to this right of amendment and termination. This right applies without limitation even after an individual's circumstances have changed.

# MISCELLANEOUS

## OFFICIAL PLAN INFORMATION

The official name of the Plan and other related information is located in the Adoption Agreement.

The financial and other records for the Plan are kept on a plan year basis. The Plan Year ends on each December 31, or such other date as set forth in the Adoption Agreement.

## PLAN SPONSOR AND PLAN ADMINISTRATOR

The plan sponsor is your Employer. Identifying and contact information for your Employer is located in the Adoption Agreement. The plan administrator is your Employer or other entity as identified in the Adoption Agreement. Contact information for the plan administrator is located in the Adoption Agreement.

## AGENT FOR SERVICE OF LEGAL PROCESS

Legal process may be served on your Employer. Identifying and contact information is located in the Adoption Agreement.

## THIRD-PARTY ADMINISTRATOR / CLAIMS ADMINISTRATOR

Discovery Benefits, LLC provides certain third-party administration services related to the Plan. Contact information is as follows –

Discovery Benefits, LLC
4321 20th Avenue S
Fargo, ND 58103
Phone: (866) 451-3399
Fax: (866) 451-3245
www.discoverybenefits.com

## PLAN FUNDING

Contributions for Plan coverage are made by your Employer. Benefits are self-insured and paid out of general assets of your Employer. The Claims Administrator is not responsible for funding or insuring Plan benefits.

## NO GUARANTEE OF EMPLOYMENT

Nothing in the Plan or this SPD may or can be interpreted as a guarantee of future employment or continued employment for any duration.

## ANTI-ASSIGNMENT RULES

Your rights and benefits under the Plan cannot be assigned, sold or transferred to any person, including your healthcare provider. For this purpose, your Plan rights and benefits, include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal, and any other Plan rights and benefits, whether actual or potential. Any purported assignment of rights and/or benefits under the Plan shall be void and shall not apply to the Plan. Further, a payment or reimbursement of eligible expenses by the Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

In addition, during a visit to your healthcare provider, your provider may ask you to authorize him / her to receive payments directly for your covered healthcare services. Such authorizations to receive direct payments are not assignments of benefits or rights under the Plan. Further, such authorizations are void and will not apply to the Plan.

Any payments made directly to you of claims for benefits will fulfill the Plan's obligation to make a payment. The Plan is not responsible for paying healthcare provider invoices that are balance-billed to you.

## AUTHORIZED REPRESENTATIVE RULES

You may appoint an authorized representative to act on your behalf for purposes of the Plan.

If you need to appoint an authorized representative for any purpose, your appointment of an authorized representative must:

- Be in writing and dated;
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative;
- Be signed by you and notarized by a notary public;
- Satisfy any other legal requirement applicable to appointments under state or federal law; and
- Be approved by the Claims Administrator or Plan Administrator (or its delegate) in writing.

The Plan will also recognize a court order appointing a person as your authorized representative. The Claims Administrator or Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

## RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You may examine, without charge, at the Employer's office and at other specified locations, such as worksites, all documents governing the plans.

You may obtain, upon written request to the Employer, copies of documents governing the operation of the plan, including insurance contracts and copies of updated summary plan descriptions. The Employer may make a reasonable charge for the copies.

## PRUDENT ACTIONS BY PLAN FIDUCIARIES

The people who operate your plans, 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit.

## ENFORCE YOUR RIGHTS

If your claim for a plan 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. there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Employer 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 Employer. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.