SUMMARY DESCRIPTION
for the
CAFETERIA PLAN, and ACCOUNT PLANS

The Employer named below sponsors this Plan:
The City of Dardenne Prairie
Dardenne Prairie, MO 63368
The Employer accepts service of legal process.

Federal Tax ID: 43-1493121

Plan Name: The The City of Dardenne Prairie **Cafeteria Plan and Account Plans**

Group Name, if applicable: N/A

Plan Effective Date: 1-1-2022

Plan Year: 1-1 to 12-31

Account Plans included in this Plan: Healthcare FSA, Healthcare Premium (NESP) Reimbursement Account 2022

Run Out - Number of Days: 91

Carryover Maximum: $570.00

Grace Period: N/A

'You' and 'Your' refer to an Employee who has enrolled in at least one Qualified Benefit Plan for the current Plan Year, or has a carryover balance from an existing Account Plan, when a Carryover is allowed as indicated above. 'You' and 'Your' are also referred to as a 'Participant'.

Purpose. Your Employer has adopted this Plan to allow You to pay for benefit options (called Qualified Benefit Plans) for Yourself, Your spouse, and Your dependents via pre-taxed salary reduction contributions. You may choose from these "tax free" Qualified Benefit Plans in lieu of receiving taxable compensation. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code. This Plan allows You to reduce Your taxable income in direct proportion to (a) Your contribution to the cost of Your elected Qualified Benefit Plans and (b) Your contribution to any Account Plan.

Qualified Benefit Plans. A Qualified Benefit Plan is a tax advantaged Plan pursuant to Section 125(f) of the Internal Revenue Code. The list of Account Plan(s) made available for the current Plan Year is provided above. The list of other Qualified Benefit Plans is provided in the Enrollment Materials provided by Your Employer at the time of enrollment, expressly incorporated by reference into this Summary Description.

If You are not eligible to participate in this Plan but are allowed to participate in any Qualified Benefit Plan then Your costs will be paid with taxable income and Your compensation will not be reduced by the Employer.

Enrollment Materials. The Enrollment Materials are expressly incorporated by reference into this Summary Description and include benefit guides and summary benefit descriptions that provide the following detail for the Qualified Benefit Plans offered by Your Employer:

1) Complete detailed schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances in which benefits will be coordinated with other sources of payment;
2) Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;
3) The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the Plan for the redress of claims which are denied in whole or in part. Additional detail required by law for specific claims and appeals will be furnished as separate documents without charge;
4) Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the Participant or beneficiary will be responsible;
5) Any annual or lifetime caps and all other limits on benefits;
6) The extent to which preventive services are covered;
7) Whether, and under what circumstances, existing and new drugs are covered;
8) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
9) Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
10) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;
11) A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to Participants and beneficiaries as a separate document at no charge;
12) Any circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits; and,
13) Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third-Party Administrator.

An Employee's right to enroll in and maintain coverage under the Qualified Benefit Plans are described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health Plans are required to cover

dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);

2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage;
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each Participant, also contains important information about the potential special enrollment rights including a 30 day time limit for requesting the enrollment. You can contact Your Benefits Coordinator to receive an additional copy of that notice; and,
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
   (a) The employee or dependent were covered under a Medicaid Plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
   (b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

This Plan defines an eligible Employee to be an individual classified by the Employer as a common-law employee who is typically on the employer's W-2 payroll. 'Employees' does not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Administration. Your Employer has sole discretionary powers and is responsible for the administration of this Plan and the Qualified Benefit Plans. Should You need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Employer has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

No Continued Employment. No provisions of the Plan or this Summary Description grant any Employee any rights of continued employment with the Employer or in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

ACCOUNT PLANS

The Account Plans offered for the current Plan Year are listed above on the first page of this Summary Description. Your Employer appoints TASC as its Service Provider to maintain certain Account Plan records and to be responsible for the Account Plan's day-to-day administration. TASC is not a Plan and has no discretionary authority over the Plan.

The Participant Reference Guide. The Participant Reference Guide which is incorporated by express reference into this Summary Description, includes all the information You need to access Your Account Plans and submit requests for reimbursement. By signing into Your online Account Plan, You may access information about Your enrollment, available funds, annual election, total contributions, and total reimbursements.

Age Requirement. No maximum age requirement may be imposed for participation in an Account Plan.

Re-employment of Former Employees. A former Employee rehired within thirty (30) days of termination will immediately be reinstated into their original Account Plan elections. A former Employee rehired after thirty (30) days of termination will be allowed to make new Account Plan elections.

Excess Payments. Upon any benefit payment made to an Accountholder in error under an Account Plan, said Accountholder will be informed and required to repay the errant amount. This includes and is not limited to amounts over

the Accountholder's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid Request for Reimbursement (RFR) upon request is not provided. The Employer may take reasonable steps to recoup the excess payment including withholding the amount from future salary or wages and subtracting from future benefit reimbursement(s). You will be allowed to submit valid claims to offset any amount due.

Non-Assignment of Benefits. No Accountholder or beneficiary may transfer, assign or pledge any Account Plan benefits except as may be required pursuant to a "Qualified Medical Child Support Order" (which provides for Plan coverage for an alternate recipient), other applicable law, or payment made directly to a healthcare provider.

Termination Of Participation. Accountholders are enrolled in the Account Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be an Accountholder due to the following events:

a. Your death, resignation or termination of employment with the Employer;
b. This Plan terminates;
c. You fail to pay any required premium (including payment by salary reduction) under the Plan;
d. You no longer meet the requirements for eligibility in the Plan; or,
e. You revoke Your election under a qualifying change in status event.

Your actual termination date due to these events will vary depending on the Account Plan and Your Employer's Account Plan design. Check with Your Employer for Your actual termination date. After Your termination in an Account Plan, you can only be reimbursed for services rendered prior to your eligibility end date and submitted before the end of the Run Out Period specified on the first page of this Summary Description.

Change In Status Events. The laws governing Account Plans generally do not allow You to change Your benefit and contribution elections during a Plan Year (except for Health Savings Accounts; see below). Your elections are irrevocable and any balance in Your account at the close of the Plan Year is forfeited and becomes the property of Your Employer (refer to the first page of this Summary Description to see if there is a Grace Period or Carryover). This irrevocable election rule does not apply if You experience a qualifying change in status event. The election change request must be on account of and consistent with the change in status event.

Any request to change Your election must be submitted in writing within 30 days of the occurrence of a change in status event. The new benefit elections start after the change in status event has occurred and the paperwork has been filed. This Plan is intended to allow any change in status event that is allowed by the IRS. The following change in status events are applicable:

- A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
- The adoption, birth, or death of a child or dependent.
- Dependent satisfies or ceases to satisfy dependent eligibility requirements.
- The change in employment status of You, Your spouse or dependent.
- Change in Your residence. *
- Beginning or ending adoption proceedings.
- Automatic changes upon cost increases or decreases. *
- Significant cost increases. *
- Significant curtailment of coverage. *
- Addition or elimination of similar benefits package option. *
- Change in coverage of a spouse or dependent under an employer Plan. *
- FMLA.
- HIPAA special enrollment rights. *
- Qualifying continuation event.
- Loss of group health coverage sponsored by governmental or education institution. *
- A judgment, decree or order requiring coverage for a spouse or child.
- Medicare or Medicaid entitlement.

- Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. *
- Eligibility for Employment Assistance under Medicaid or SCHIP. *
- Exchange Event – A loss of eligibility under the terms of the Plan due to a reduction in hours (less than 30) – even when the Employer allows the coverage to continue in effect during the 'Stabilization Period' to satisfy the Affordable Care Act coverage requirements. *
- Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period.*

**These qualifying change in status events do not apply to the Healthcare FSA.*

Notes:

1. If You are making tax free contributions to a Health Savings Account (HSA) under this Plan, You do not need a change in status event to change Your HSA election. You may prospectively change Your HSA election at any time during the Plan Year.

2. For the termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the Employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

Grace Period or Carryover. As a terminated Accountholder, You are not eligible for the Grace Period or Carryover (when offered by Your Employer) unless You are an active Accountholder in the Plan and Your Paid Coverage Period continues through the last day of the Plan Year.

The Family And Medical Leave Act ('THE FMLA') and Unpaid Leave. The FMLA requires employers with 50 or more employees to provide unpaid leave for eligible employees under circumstances that are prescribed by applicable federal law, including the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) as amended.

The payment option(s) for coverage while on unpaid Family Medical Leave Act leave and for unpaid leave for Healthcare Account Plans are:

1) Pre-pay. Under this option, you will pay Your election amounts that will be due during your leave, before your FMLA leave begins. The payments may be either pre-tax or after-tax, according to the terms of your Salary Reduction Agreement.
2) Pay-as-you-go. Under this option, You will pay your share of Your election amounts on the same schedule as if You were not on leave. If You fail to make payments under this Pay-as-you-go option, Your Employer is not required to continue coverage. However, if Your Employer chooses to continue coverage, Your employer is entitled to collect these amounts from you after You return from the FMLA leave.

If an Accountholder's coverage under the Plan ceased while on FMLA leave, the Accountholder will be entitled to resume coverage upon return from leave on the same participation basis in effect prior to the leave, or as otherwise required under the FMLA. The Accountholder will be entitled to elect reinstatement in the Plan at the coverage level that was in effect before the FMLA leave, with increased contributions if necessary to reach their annual election. Or, the Accountholder can continue with the amount withheld from the Accountholder's compensation on payroll-by-payroll basis equal to the amount withheld before the FMLA leave.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA). The first page of this Summary Description indicates whether this Plan includes a Healthcare Flexible Spending Account. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder 's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or

alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

Uniform Coverage Rule. The entire amount of your annual Healthcare FSA election is available to You for services rendered on any day of the Plan Year that you are covered by the Healthcare FSA.

Limitations and Exclusions. The following examples—even those recommended by a doctor—do not qualify as expenses eligible for reimbursement under the Healthcare FSA: insurance premiums; expenses for cosmetic procedures or cosmetic items; items that are for an Accountholder's general wellbeing; items the Accountholder would have purchased even if the Accountholder had no medical condition (for example, a toothbrush); vacation and travel expenses even if for rehabilitation or prescribed by a doctor; long-term care expenses that are not for actual medical care; expenses incurred in stockpiling over-the-counter items in quantities that could not reasonably be used during the current Plan Year.

Qualified Reservist Distribution**.** An Accountholder who is called to active duty in the US Armed Services and enrolled in the Healthcare FSA may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Healthcare FSA subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount You have contributed to the account that has not been used to reimburse You for RFRs submitted.

Qualified Medical Child Support Order (QMCSO). The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of an Accountholder in a group health Plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health Plan under which an Accountholder or other beneficiary is entitled to receive benefits. Accountholders may obtain, without charge, a copy of the Plan's procedures from the Plan.

Family and Medical Leave Act (FMLA). If You go on a qualifying leave under FMLA, to the extent required by the FMLA, Your Employer will continue to maintain Your benefit package options providing health coverage (including the Healthcare FSA) on the same terms and conditions as if You were still active (that is, Your Employer will continue to pay its share of the contribution to the extent You opt to continue coverage). Your Employer may require You to continue coverage while You are on paid leave (as long as Accountholders on non-FMLA paid leave are required to continue coverage). If so, You will pay Your share of the contributions by the method normally used during any paid leave.

If Your coverage ceases while on FMLA leave, You will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as You had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which You did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave**.** If You are going on unpaid FMLA leave and You opt to continue Your Medical and Dental Insurance Benefits and Healthcare FSA Benefits, then You may pay Your share of the contributions in one of three ways:

(1) Prepay. Your share of contributions due during Your leave may be paid either pre-tax or after-tax before Your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
(2) Pay-as-You-go. Your share of contributions will be paid on the same schedule as if You were not on leave or under another schedule. Per the Department of Labor regulations, if You fail to make payments under this option, Your Employer is not required to continue coverage. If Your Employer chooses to make payment and thereby continue coverage, Your Employer is entitled to recoup these amounts from You after You return from leave.
(3) Catch-up. Your Employer may advance Your share of contributions while You are on leave. Upon Your return from leave, Your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with Your Employer to determine if this option is available under Your Plan.

Non-FMLA Leave**.** If You go on an unpaid leave of absence that does not affect eligibility, then You will continue to participate and the contribution due from You will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan. If You go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave**.** If You take a leave of absence due to military service, You may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Health Savings Account (HSA): If You contribute to a Health Savings Account (HSA) then You may only enroll in a ***Limited Purpose Healthcare FSA*** **(LPFSA**). Qualified Expenses under an LPFSA are limited to dental and vision services or supplies excluded from coverage under Your high deductible health plan, or unpaid amounts incurred after the HDHP statutory annual deductible has been satisfied. The LPFSA will not provide reimbursement for any other service or supply regardless of whether that service or apply is allowed by the IRS as a medical expense or allowed under a General-Purpose Healthcare FSA.

HealthCare FSA Continuation Coverage Rights Under The Public Health Services Act. Under the Public Health Service Act §2201 [42 USC §300bb-1] as amended, continuation coverage is mandated. This Summary Description describes Your rights for the Healthcare FSA. Your rights under any of the other Qualified Benefits Plans offered by Your Employer are described in the Summary Description(s) for that Plan and may be obtained from Your Plan.

If You elect to participate under the Healthcare FSA and are considered an Accountholder on the day before experiencing a qualifying event, continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, continuation coverage will not be offered if on the day of Your qualifying event, the amount of Your annual election less any reimbursed payments is less than the amount of premium required to continue the Healthcare FSA Plan until the end of the Plan Year. Continuation under an excepted Healthcare FSA Plan is available until the end of the Plan Year in which the qualifying event occurs.

An Accountholder who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan does not receive notification within this time period, You will lose Your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

Continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of Your monthly contribution. The Employer may require the payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

(1) Termination of employment (for reason other than "gross misconduct"); and
(2) Reduction of employee's work hours.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT. The first page of this Summary Description indicates whether this Plan includes a Dependent Care Flexible Spending Account. This account provides employees with tax free dependent care assistance only when the assistance is necessary for the Accountholder to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care FSA include any expenses that You could take as a credit against tax on Your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of Your payroll deduction on the date the RFR is processed. The tax laws further limit how much You may contribute to this account.

Under the law and the terms of the Plan, You may defer no more than the lesser of Your actual income for the year (or, if You are married and it is less, Your spouse's actual income) or $5000 per year to this Program. A married Accountholder who files separate tax returns is limited to $2500 per year. A married Accountholder who files joint returns can split this limit as they see fit.

HEALTHCARE PREMIUM (NESP) REIMBURSEMENT ACCOUNT. The first page of this Summary Description indicates whether this Plan includes a Healthcare Premium (NESP) Reimbursement Account. This account provides reimbursement for premiums You paid for employee-owned health insurance policies. Employer-provided insurance Plans and coverage offered through the Marketplace, (a state or federal Plan under the Affordable Care Act), do not qualify. Premiums eligible for reimbursement are for a period in which You were a covered Accountholder under this account.

REIMBURSEMENT DENIALS FOR ACCOUNT PLANS

Reimbursements under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account. The RFR procedure described below will apply if (a) a RFR under the Healthcare FSA, Limited Purpose Healthcare FSA, Dependent Care FSA, or Healthcare Premium (NESP) Reimbursement Account components of the salary reduction Plan is wholly or partially denied, or (b) You are denied a benefit under the salary reduction Plan due to an issue germane to Your coverage under the Plan.

If Your RFR is denied in whole or in part, You will be notified in writing within 30 days after the date the Plan received Your request. (This time-period may be extended for an additional 15 days for matters beyond the control of the Plan, including in cases where an RFR is incomplete.) The Plan will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan is expected. When an RFR is incomplete, the extension notice will also specifically describe the required information, will allow You 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on Your RFR until the specified information is provided.)

Notification of a denied RFR will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for You to validate the RFR and an explanation of why such material or information is necessary;

Appeals. If Your RFR is denied in whole or part, then You (or Your authorized representative) may request review upon written application to the Plan. Your appeal must be made in writing within 180 days after Your receipt of the notice that the RFR was denied. If You do not appeal on time, You will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that You feel Your RFR should not have been denied. It should include any additional facts and/or documents that You feel support Your RFR. You will have the opportunity to ask additional questions and make written comments, and You may review (upon request and at no charge) documents and other information relevant to Your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed, and a determination made within a reasonable time, defined as not later than 60 days after receipt of Your appeal. If the decision on review affirms the initial denial of Your RFR, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request.