Plan Document and
Summary Plan Description

for Plan Participants and Beneficiaries of

MILPITAS CHRISTIAN SCHOOLS Health and Welfare Benefits Plan

July 1, 2024

BenefitEdge Insurance Services, Inc. does not make any warranty or representation, either express or implied, that this document accurately and completely describes the health and welfare plans referenced herein, or meets the applicable legal requirements. This document should not be used as the final plan document /summary plan description for the health and welfare plans described herein without review of legal counsel.

This Plan Document and Summary Plan Description contain information the Plan Administrator is required to provide to you under federal law.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

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HIGHLIGHTS

MILPITAS CHRISTIAN SCHOOLS ("Plan Sponsor") hereby establishes the **MILPITAS CHRISTIAN SCHOOLS Health and Welfare Benefits Plan** to provide health benefits to its eligible employees, their eligible spouses and eligible dependents. The purpose of this Plan is to provide **medical, dental, vision, life (basic & voluntary), accidental death and dismemberment, and long term disability benefits to eligible employees of the Employer. The Employer is MILPITAS CHRISTIAN SCHOOLS, EIN 77-0058224. The Plan is effective December 1, 2006. The Plan is amended/restated effective July 1, 2024.**

This document (sometimes herein referred to as the summary plan description or "SPD") is the formal plan document and summary plan description under which, along with the insurance contracts, the welfare benefit plan arrangements described below and offered as the **MILPITAS CHRISTIAN SCHOOLS Health and Welfare Benefits Plan** (the "Plan") are administered. This document governs benefits provided to eligible employees and their eligible dependents.

You should read this document carefully as it contains important information about your rights and obligations under federal law and under the Plan. If you have questions about your benefits or if you disagree with a decision on your claim for benefits, you will need to refer to this document for the specific procedures you will need to follow to file a formal complaint.

You may have received additional summaries or certificates or benefit booklets ("Booklets"), either electronically or in writing, which govern the welfare plans in which you are eligible to participate. If you received a summary, certificate, or benefit Booklet electronically, you are entitled to request and receive a printed copy. The Booklets provide detailed information about the benefits to which you are entitled and the steps you must take to obtain those benefits. The Booklets are incorporated herein by this reference. If there are conflicts between the language of a Booklet and this document, the terms of the Booklet control, unless otherwise expressly indicated in this document.

In addition, you may have received additional plan documents, insurance contracts or other documents which legally govern the operation of the Plan. This document is intended to be read in conjunction with and as a supplement to the Booklets and other plan documents, except as otherwise expressly provided.

GENERAL INFORMATION

Name of the Plan

The name of the plan is the **MILPITAS CHRISTIAN SCHOOLS Health and Welfare Benefits Plan** (the "Plan").

Description of the Plan

The benefits listed below are included in this Plan. This Plan is a health and welfare plan under the Employee Retirement Income Security Act of 1974 (ERISA).

NAME	TYPE	FUNDING AND ADMINISTRATION
Kaiser HMO, DHMO	Medical	Insured, **Kaiser Permanente**
HealthNet HMO, PPO, HSA	Medical	Insured, **HealthNet of California**
Guardian Dental PPO	Dental	Insured, **Guardian Life**
Vision VSP	Vision	Insured, **Guardian Life**
Basic Life/ AD&D	Life and AD&D	Insured, **Guardian Life**
Long-Term Short-Term Disability	LTD STD	Insured, **Guardian Life**
Accident, Cancer, Critical illness	Voluntary Benefits	Insured, **Colonial**
Long Term Care	LTC	Insured, **UNUM**

Source and Amount of Contributions

Depending on the benefit arrangement, contributions are made entirely by your employer, entirely by the participating employees on a pre-tax basis, or partly by your employer and partly by participating employees. The Employer will determine, from time to time, what portion of the benefits will be paid directly by the Employer and what portion will be paid by participating employees. Any amounts paid by your employer will be described in materials provided by the Employer.

Type of Plan Administration and Payment of Benefits

All plan benefits that are outlined above under "Description of Plan. All plan benefits that are outlined above under "Description of the Plan" that are insured are administered by the insurance provider for the plan, as described in the applicable Booklet or benefits summary. The names of the insurers are listed under "Description of the Plan." All insured benefits are paid directly by the insurance providers.

Plan Sponsor

MILPITAS CHRISTIAN SCHOOLS

3435 Birchwood Lane

San Jose, CA 95132

Employer Identification Number and Plan Identification Number

The Employer Identification Number of the Plan Sponsor **MILPITAS CHRISTIAN SCHOOLS** assigned by the
Internal Revenue Service is **77-0058224**. The Plan Number is **501**.

Plan Administrator

MILPITAS CHRISTIAN SCHOOLS is the Plan Administrator of the Plan. The **Human Resources Manager** is the person who acts on behalf of the Plan Administrator.

The name, address and telephone number of the Plan Administrator is:

Attention Human Resources Manager

MILPITAS CHRISTIAN SCHOOLS

3435 Birchwood Lane

San Jose, CA 95132

(408) 945-6530

In carrying out its responsibilities under the Plan, the Plan Administrator shall have the complete and absolute discretion and authority to make all fiduciary decisions relative to the benefits payable under the Plan, including without limitation except to the extent a Booklet gives the applicable Insurer the authority to interpret the insurance policies, interpretations of Plan documentation, determinations, of eligibility and benefit entitlement, and all other decisions necessary to administer the Plan. These powers include, but are not limited to:

- To make and enforce such rules and regulations in its sole and absolute discretion as it deems necessary or proper for the efficient administration of the Plan which are not inconsistent with the terms of the Plan or ERISA.

- To interpret the Plan documents in its discretion. Such interpretation is final and conclusive on all persons claiming benefits under the Plan.

- To use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty in connection with the Plan.

- To allocate fiduciary responsibilities by written instrument signed in the same manner as provided for delegations.

- To designate other individuals, corporations or other entities to carry out fiduciary responsibilities, obligations and duties under the Plan, and to revoke, modify or change any such delegation, revocation or modification by written instrument.

In carrying out its responsibilities, the Plan Administrator shall be fully protected to the fullest extent permitted under ERISA. In the event of any delegation in accordance with the above, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. Fiduciary responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary or in accordance with the terms of this SPD.

The Plan Administrator is authorized to delegate any or all of its responsibilities and powers with respect to the Plan, which delegation (if made) shall be evidenced by a designation in writing.

Name and Address of Agent for Legal Process

Legal process may also be served upon the **President** or the Plan Administrator.

Named Fiduciary

President MILPITAS CHRISTIAN SCHOOLS

3435 Birchwood Lane

San Jose, CA 95132

(408) 945-6530

Plan Year

The records for the Plan are maintained and reported on a twelve-month period of time, known as the Plan Year. The Plan Year begins on **July 1st** and ends on **June 30th.**

DESCRIPTION OF BENEFITS

A description or summary of each benefit arrangement is contained in a separate Booklet or benefits summary for each plan. The Booklet may also make reference to schedules of benefits or certificates of coverage. These are available without cost to any participant or beneficiary who so requests.

Eligibility for Benefits

Active employees of the Employer (and their eligible dependents) are eligible to participate in the benefits described above as follows:

> **Full-Time Employees, who work at least 30 hours per week, are eligible to participate in the following benefits on first of the month following 30 days from the date of hire: medical, dental, vision, life, accidental death and dismemberment, and long term disability**

Generally, an employee and the employee's eligible dependents must enroll in the Plan within **30 days** of eligibility. An annual enrollment period will be offered at such dates as the Plan Administrator shall determine. Special enrollment rights are available under the Health Plans pursuant to HIPAA (see the HIPAA Privacy and Security Rule Section of this document).

For information regarding who qualifies as a "dependent" for an underlying benefit in this Plan, please refer to the applicable benefit Booklet or summary.

Cessation of Participation

Employees shall cease to be participants in the Plan on the date on which they leave the employment of **MILPITAS CHRISTIAN SCHOOLS**, unless such departure is for an authorized leave of absence, such as under the Federal Family Medical Leave Act or other leave program maintained by the Employer. (See discussion of COBRA later in the document.)

Disqualification for Benefits

Your eligibility to participate in the Plan will end:

- In accordance with the terms of the applicable Booklet,
- When the Plan is discontinued or terminated,
- When you fail to make any required contribution within in accordance with the

Employer Policy after the due date, in accordance with the applicable policy,

- When you are no longer working in an eligible class,

- For an enrolled dependent, when he or she no longer meets the requirements to remain an eligible dependent,

- As a result of an act, practice or omission that constitutes fraud or as a result of an intentional misrepresentation of a material fact. Such action may result in both a loss of prospective eligibility and the retroactive rescission of coverage back to the date of the fraud or misrepresentation.

- In cases where a participant commits acts of physical or verbal abuse that pose a threat to the claim administrator, an insurance provider, or the plan administration or staff.

Additional circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits are described in the applicable Booklet or summary of benefits.

PLAN DOCUMENTS

The Plan Documents consist of this document, the benefits Booklets describing the plans listed above, any Summary of Material Modifications, certificates of insurance, group insurance contracts and the formal interpretations adopted by the Plan Administrator and memorialized in writing. Upon written request to the Plan Administrator, copies of any or all of the Plan Documents will be furnished to a Plan participant or beneficiary at a nominal charge.

AMENDMENT AND TERMINATION OF THE PLAN

MILPITAS CHRISTIAN SCHOOLS shall be entitled to amend or terminate the Plan, in whole or in part, at any time by appropriate corporate action. This includes, without limitation, the right to increase or decrease the amount of the employer contribution or, if applicable, the eligible employees' contributions to any or all of the benefit arrangements, at any time, and to modify all or any part of the coverage with respect to any or all of the participants covered by the benefit arrangement.

Payment of benefits for covered expenses incurred prior to the effective date of a Plan Amendment shall be based upon the Plan provisions in effect at the time the covered expenses were incurred.

Upon termination or discontinuance of any benefit arrangement, you will not have any further rights, other than for the payment of covered benefits incurred before such plan was terminated. The amount and form of any final benefit you or your beneficiary receive will depend on the Plan Documents, as described above in the Section entitled "Plan Documents," and the Plan Administrator's decisions.

CONTRACT

This Plan shall not be deemed to constitute a contract between the Employer and any eligible employee or participant or to be a consideration or an inducement for the employment of any eligible employee. Nothing contained in this Plan shall be deemed to give any eligible employee or participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any eligible employee or participant at any time regardless of the effect which such discharge shall have upon him or her as an eligible employee or participant in this Plan.

INTERPRETATION AND CONSTRUCTION

This Plan shall be construed and enforced in accordance with the laws of the following state(s): **California** to the extent these laws are not otherwise pre-empted by Federal law.

CLAIMING BENEFITS

The claims procedures provided in the relevant Summary Plan Description or benefits Booklet shall control over this general provision. An eligible employee shall make a claim for benefits utilizing such documentation as shall be provided by the Plan Administrator from time to time. If a claim is denied, in whole or in part, notice of the denial shall be furnished to the claimant within a reasonable period of time, not to exceed 30 days after the receipt of the claim by the Plan Administrator, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 30 day period. In no event shall such extension exceed a period of 15 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring the extension of time, and the date on which the Plan Administrator expects to render a decision. The Plan Administrator shall provide every claimant who is denied a claim for benefits a written notice setting forth, in a manner calculated to be understood by the Plan participant, the following:

- A specific reason or reasons for the denial;
- A specific reference to pertinent Plan provisions or documentation upon which the denial is based;
- A description of any additional material and information needed from the claimant to complete the claim and an explanation of why such material or information is necessary; and
- An explanation of the Plan's claims review procedure.

Appealing a Denied Claim

The claimant or their authorized representative may appeal a denied claim within 180 days of receiving the denial. The claimant may review any pertinent documents and submit issues and comments in writing. Claims shall be filed as provided in the relevant Summary Plan Description or Booklet.

The designated entity will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on review will be made in writing within 60 days of receiving the written request for review. The final decision shall include the reasons for the decision with reference, again, to those policy or plan provisions upon which the final decision is based.

Before you are entitled to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, you must exhaust all of the claims review procedures described in the applicable benefits Booklet or Summary Plan Description.

For insured benefits, all levels of appeal have been delegated to the applicable insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. You are not entitled to appeal the decision of the insurance company to the Plan Administrator.

In certain circumstances you may have a right to have a denied claim reviewed by a third party reviewer. See the applicable Summary Plan Description or other Plan documents.

Standard of Review

The standard of review of decisions by the Insurer or the Plan Administrator shall be determining (a) whether the decision by the Insurer is based on substantial evidence, and (b) whether the decision by the Insurer is arbitrary and capricious.

RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As participants in an employee welfare benefit plan, participants have certain rights and protections. ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed 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 ERISA Plan, including insurance contracts and updated summary plan descriptions. If the ERISA plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The Administrator may make a reasonable charge for the copies.

- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under a program 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 documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, (if your plan has such an exclusionary period) when you have creditable coverage from another plan. The recent health care reform law generally provides that pre-existing condition exclusions cannot be imposed against enrollees under age 19; consult your Summary Plan Description or other Plan documents to determine whether this rule applies in your situation. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, if you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA 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.

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 above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan 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 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 ERISA 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 ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're 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're successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest offices of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20240.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1.866.444.3272.

SPECIAL PROVISIONS APPLICABLE TO GROUP HEALTH PLANS

The following provisions apply only to the benefit arrangements under this Plan that are group health plans. To the extent that any of these provisions are inconsistent with a Booklet or summary plan description, this document shall supersede the Booklet. In addition, to the extent that the plan is governed by state mandates, and those mandates are inconsistent with any provision below, the state mandates shall supersede to the extent required by law.

Qualified Medical Child Support Order

If a Health Plan receives a qualified medical child support order recognizing the right of any child of a participant to enrollment under the Health Plan, such child shall be enrolled as required under the terms of the order. Qualified medical child support orders shall be administered in accordance with procedures adopted by the Plan Administrator. You may obtain without charge a copy of such procedures from the Plan Administrator.

Family and Medical Leave

Certain employers are required to comply with the Family and Medical Leave Act ("FMLA"). If your employer has to comply with the FMLA, you will have the rights described below. If a Participant is on an unpaid leave to care for a newborn; to care for a child placed with the Participant for adoption or foster care; or for a serious health condition of the Participant or the Participant's spouse, child or parent, coverage for the Participant and eligible dependents will be continued for up to twelve (12) weeks. The Employer will continue to pay for coverage to the extent required by law. To maintain eligibility, the employee must continue to contribute the same share of cost of coverage that he or she would pay when not on leave.

Military Leave

Employees going into or returning from military service may elect to continue Health Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights apply only to eligible employees and eligible dependents covered under the Health Plan before leaving for military service.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage, or your spouse or eligible dependent children's coverage, pursuant to USERRA, you will be required to pay up to 102% of the full premium for coverage elected under the Health Plan. However, if your active duty is for 30 days or less you are not required to pay more than the amount that you pay as an active employee for the coverage. Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Definitions

"Uniformed Services" - means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

"Service in the uniformed services" or "service" - means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response personnel of the National Disaster Medical System.

All of the undefined words used in this USERRA notice have the meanings assigned to them under COBRA.

Duration of USERRA Coverage

When a covered employee takes a leave for service in the uniformed services, USERRA coverage for the employee, and for covered dependents for which coverage is elected, begins the day after the employee, and covered dependents, lose coverage under the Plan, and it can continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Your right to continue coverage under USERRA will end if you do not notify us of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work, if your uniformed services was for less than 31 days, or applying for reemployment, if your uniformed service was for more than 30 days. The time for returning to work depends on the period of uniformed service, as follows:

PERIOD OF SERVICE	**RETURN-TO-WORK REQUIREMENT**
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.

Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. This means that COBRA coverage and USERRA coverage begin at the same time. If COBRA and USERRA give you or your covered spouse or dependent children, different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described for COBRA below (for example, the procedures for how to elect COBRA coverage and paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Note, COBRA coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described below). In contrast, USERRA coverage can continue for up to 24 months, as described above.

Benefits After Covered Mastectomy

After a covered mastectomy, the Health Plan will cover the medical and surgical benefits for the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses (implants, special bras, etc.) and physical complications for all stages of a mastectomy, including lymph edemas (swelling associated with the

removal of lymph nodes) in a manner determined appropriate in consultation with the attending physician and the patient.

Coverage for breast reconstruction and related services will be subject to all applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Health Plan.

The Health Plan will at all times comply with the terms of the Women's Health and Cancer Rights Act of 1998 and will not deny a patient eligibility, or continued eligibility to enroll or to renew coverage, under the terms of the Health Plan solely to avoid the requirements of this section. Additionally, the Health Plan will not penalize the patient or physician, or induce him or her to provide care to a participant in a manner inconsistent with this provision.

Any Health Plan exclusions or limitations that exclude the benefit described above are hereby omitted to the extent that they specifically prohibit the above coverage.

Mental Health Benefits

Benefits under a Health Plan shall be provided in compliance with the Mental Health Parity Act of 1998. The aggregate lifetime limit on benefits and/or annual dollar limit on benefits contained in the Booklets shall apply both to medical and surgical benefits and to mental health benefits.

Newborns' and Mothers' Health Protection Act of 1996

For Insured Programs that provide maternity or newborn infant coverage, special rights upon childbirth under the Newborns' and Mothers' Health Protection Act of 1996, as amended and state law, as applicable, are described in the Booklets for the applicable Insured Program.

Health Insurance Portability and Accountability Act of 1996 (" HIPAA")

HIPAA provides certain limitations on preexisting condition exclusions and permits you to avoid the imposition of such exclusions by providing a certificate of creditable coverage. HIPAA also prohibits discrimination against you based on your health status and provides you special enrollment rights. If you are unsure whether a particular program is a Health Plan subject to HIPAA, please contact the Plan Administrator.

Preexisting Condition Limitations

The preexisting condition limitations in the Health Plan, if any, are described in the applicable SPD, or summary of benefits. The recent health care reform law limits whether some plans can impose preexisting condition limitations on enrollees under age 19.

Certificate of Creditable Coverage

The Health Plan will provide a certificate of creditable coverage to participants and dependents covered under the Health Plan as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at the following times:

- With respect to qualified beneficiaries who are entitled to elect COBRA continuation coverage, at the time they lose coverage under a plan in the absence of COBRA continuation coverage or alternative coverage.

- With respect to individuals who are not qualified beneficiaries under COBRA, at the time they cease to be covered under the plan.

- With respect to qualified beneficiaries who elect COBRA continuation coverage, at the time the individual's coverage ends under COBRA.

- Upon a participant's (or his or her spouse's or eligible dependent's) request, if such request is made within 24 months after the individual loses coverage under the plan.

Creditable coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. However, the following are not "creditable coverage": accident only plans, disability income plans, liability and limited scope insurance, credit only insurance, coverage for on site medical clinics, coverage issued as supplemental to liability insurance automobile medical coverage, Workers' Compensation, and limited scope dental or vision\plans.

Nondiscrimination

Eligibility for benefits under the Health Plan will not be conditioned on any health status related factors such as health status, medical history, evidence of insurability, claims history, or genetic information. The Health Plan will not charge a contribution that is greater than the charge for a similarly situated individual based on any health status related factor. The Health Plan may offer premium discounts for a bona fide wellness program.

Special Enrollment Periods

Federal law requires Health Plans to provide "Special Enrollment Period" for certain individuals who previously refused coverage or individuals who became dependents through marriage, birth, adoption, or placement for adoption (as described further below). A person who enrolls during a special enrollment period is not considered a "late plan participant" for purposes of the Health Plan.

The Health Plan will provide a Special Enrollment Period for an employee or dependent who is eligible, but not enrolled in the Health Plan, if each of the following conditions is met:

- He or she is eligible, but not enrolled, for coverage under the terms of the Health

Plan;

- He or she had other health plan coverage at the time coverage was previously offered;

- He or she states in writing when declining enrollment that the other coverage was the reason for declining enrollment (if required by the Plan Administrator at the time the individual previously declined enrollment);

- He or she loses coverage because (1) his or her COBRA continuation coverage expires, (2) the employee or dependent is no longer eligible for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including as a result of failure to pay premiums on a timely basis or termination of coverage for cause); or (3) the employer ceases making contributions toward such coverage; and

- He or she requests a special enrollment right within thirty days after the exhaustion or termination of other coverage.

After an employee or eligible dependent gives the completed request of enrollment to the Plan Administrator, his or her enrollment is effective no later than the first day of the next calendar month.

The Health Plan will also provide a Special Enrollment Period for an employee or dependent as follows:

- For an employee who is eligible but not enrolled in the Health Plan and declined coverage under the Health Plan during a prior Enrollment Period, (1) at the time of his or her marriage, and (2) at the time an individual becomes his or her dependent through marriage, birth, adoption, or placement for adoption;

- For a spouse of a participant (1) at the time of his or her marriage or (2) at the time an individual becomes a dependent of the participant through birth, adoption, or placement for adoption;

- For an individual who becomes a dependent of the participant through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period will extend for 30 days after the marriage, birth, adoption, or placement for adoption. **[Note: Some states may allow a longer period to enroll.]** For a Special Enrollment due to marriage, enrollment is effective no later than the first day of the month following the date the Employer receives the request for enrollment. For a special enrollment due to birth, adoption, or placement for adoption, enrollment is effective as of the date of the birth, adoption, or placement for adoption.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

HIPAA Privacy and Security Rules

Privacy Rules

The Health Plan is required by law to protect the privacy of certain health information that it may use or disclose. Employees will be provided with a Notice of Privacy Practices at the time an employee is enrolled in the Health Plan that describes how the health plan may use or disclose health information, the employer's rights with respect to your health information, and the Health Plan's duties with respect to your health information.

Employer Uses and Disclosures of Protected Health Information

The Plan may provide certain individually identifiable information of Plan participants and beneficiaries, including Protected Health Information, as defined in 45 CFR § 160.103, to the Employer in the Employer's capacity as the plan sponsor of the Plan. The Employer, as the plan sponsor, may use and disclose Protected Health Information to administer the Plan, as further described in this section, and other Plan documents; provided, however, such uses and disclosures shall not exceed that which would be allowable for the Plan under HIPAA. A reference in this section to HIPAA means the law as in effect or as amended.

HIPAA Privacy Rule Employer Obligations

The Employer, as plan sponsor, hereby certifies to the Plan that the Employer will:

- Not use or further disclose the information other than as permitted or required by this section or such other plan documents or as required by law.
- Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Employer, as plan sponsor, with respect to such information.
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses and disclosures provided for in this section of which it becomes aware.
- Make available Protected Health Information in accordance with HIPAA's access requirements.

- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with HIPAA.

- Make available the information required to provide an accounting of disclosures and document such disclosures of Protected Health Information.

- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA.

- If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that adequate separation between the Plan and the Employer, as plan sponsor, is maintained.

HIPAA Security Rule Employer Obligations

The Employer, as plan sponsor, further certifies that if it creates, receives, maintains, or transmits any Electronic Protected Health Information (as defined in 45 CFR § 160.103) on behalf of the Plan, the Employer will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

- Ensure that the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures.

- Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect the information.

- Report to the Plan any security incident of which it becomes aware.

Access to Protected Health Information

- **Classes of Employees**

  The following classes of employees or other workforce members under the control of the Employer may be given access to Protected Health Information received from the Plan or a health insurance issuer or business associate providing services to the Plan: **human resources.** The list includes every class of employees or other workforce members under the control of the Employer who may receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to Protected Health Information only to perform the plan administration functions that the Employer provides for the Plan.

- **Disciplinary Action**

  The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Protected Health Information in breach or violation of or noncompliance with the provisions of this Section. The Employer will promptly report such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the breach, violation, or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance

- **Security Measures**

  The Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic Protected Health Information on behalf of the Plan.

Interpretation

Any ambiguity in this section or in determining controlling provisions shall be resolved in favor of an interpretation that permits the Plan to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this section and mandatory provisions of HIPAA, the HIPAA provisions shall control.

Appendix A: COBRA Notice

** Continuation Coverage Rights Under COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

BenefitEdge Insurance
18181 Butterfield Blvd Ste 115
Morgan Hill, CA 95037
(888) 995-3343

Notice Procedures: Any notice that you provide must be in writing and sent either by US Mail or facsimile to BenefitEdge Insurance or MILPITAS CHRISTIAN SCHOOLS Oral notice, including notice by telephone, is not acceptable.
Notice to anyone other than BenefitEdge Insurance or MILPITAS CHRISTIAN SCHOOLS is not a valid notice and will not be accepted as a valid notice. You must mail your notice to this address:

BenefitEdge Insurance Services, Inc.
18181 Butterfield Blvd, Suite 115
Morgan Hill, CA 95037

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan or Plans, the name and address of the employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. Your notice of disability must include a copy of the Social Security Administration's determination.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

BenefitEdge Insurance Services, Inc.
18181 Butterfield Blvd, Suite 115
Morgan Hill, CA 95037
(888) 995-3343

Notice Procedures: Any notice that you provide must be in writing and sent either by US Mail or facsimile to BenefitEdge Insurance or Milpitas Christian Schools Oral notice, including notice by telephone, is not acceptable. Notice to anyone other than BenefitEdge Insurance or Milpitas Christian Schools is not a valid notice and will not be accepted as a valid notice. You must mail your notice to this address:

BenefitEdge Insurance Services, Inc.
18181 Butterfield Blvd Suite 115
Morgan Hill, CA 95037
(888) 995-3343

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan or Plans, the name and address of the employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. Your notice of disability must include a copy of the Social Security Administration's determination.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If you decide to join a Medicare drug plan, your MILPITAS CHRISTIAN SCHOOLS coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under MILPITAS CHRISTIAN SCHOOLS Health and Welfare Benefits Plan is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your MILPITAS CHRISTIAN SCHOOLS prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with MILPITAS CHRISTIAN SCHOOLS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MILPITAS CHRISTIAN SCHOOLS changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
• Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	7/1/2024
Name of Client /Sender:	MILPITAS CHRISTIAN SCHOOLS
Contact--Position/Office:	Human Resources
Address:	3435 Birchwood Lane, San Jose, CA 95132
Phone Number:	(408) 945-6530