BEDFORD COUNTY PUBLIC SCHOOLS

HEALTH AND WELFARE PLAN

Originally Effective **July 1, 2007**
Amended and Restated as of **July 1, 2021**

Bedford County Public Schools
311 South Bridge Street
Bedford, VA 24523

TABLE OF CONTENTS

SECTION 1 – ESTABLISHMENT AND PURPOSE

1.1 Establishment and Purpose

Bedford County Public Schools ("The Schools") has established the Bedford County Public Schools Health and Welfare Plan (the "Plan") for the purpose of providing health and welfare benefits to its eligible employees, eligible pre-age 65 retirees, and their eligible dependents. This Plan is established in conformance with the documentation requirements of the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA") for purposes of the health plan components contained herein, and with the requirements imposed on health plans under the Patient Protection and Affordable Care Act ("ACA") and all other applicable law.

1.2 Original Effective Date

This Plan originally took effect on July 1, 2007.

1.3 Amendment and Restatement

This Restatement reflects all changes made to the Plan, including all changes required to achieve compliance with applicable federal regulations as of July 1, 2021.

1.4 Plan Year

The Plan Year of the Plan is July 1 through June 30 of the following calendar year.

1.5 The Plan

Certain details regarding the terms and conditions of the Plan are contained in the insurance policies purchased by The Schools on behalf of its employees and the self-insured plan documents that describe the benefit programs ("Component Plans") of the Plan. Each Component Plan's benefit booklets and certificates, plan documents, and other governing documents, including any exhibits, supplements, addendums, or amendments thereto (collectively the "Benefit Documents"), when taken with this Plan document constitute the entire Plan. The Component Plans are listed in Appendix A.

1.6 Health Insurance Portability and Accountability Act

The Plan will reasonably and appropriately safeguard Protected Health Information ("PHI") created, received, maintained, or transmitted to or by The Schools on behalf of the Plan in accordance with the requirements of HIPAA. The HIPAA provisions described herein apply only to the health plan Component Plans as defined in 45 CFR Section 160.103. They do not apply to non-health component coverage contained in this Plan.

SECTION 2 – ADMINISTRATION OF THE PLAN

2.1 In General

The Schools has designated itself as the Plan Administrator of the Plan, and is a Named Fiduciary. The Schools is the Plan's agent for service of legal process.

The Schools shall have authority and responsibility to control and manage the operation and administration of this Plan. The Schools shall discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

The Schools, as Plan Administrator, shall retain the authority to delegate to officers and employees of The Schools such responsibilities as are imposed on The Schools by the terms of this instrument, together with the authority to control and manage the operation and administration of the Plan.

2.2 Plan Administrator Powers and Responsibilities

Administration of the Plan. Subject to Section 2.3, the Plan Administrator shall have all powers necessary to administer this Plan, including, in its sole discretion, the power to construe and interpret the Plan documents; to decide all questions relating to an employee's eligibility to participate in the Plan; to determine the amount, manner, and timing of any payment of benefits or change in accordance with the Plan; and to appoint or employ advisors, including legal counsel, to render advice with respect to any of the Plan Administrator's responsibilities under the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator shall be final, conclusive, and binding. All actions by the Plan Administrator shall be taken pursuant to uniform standards applied to all persons similarly situated.

Records and Reports. The Plan Administrator shall be responsible for maintaining sufficient records to reflect the compensation and benefits of each participant. The Plan Administrator shall be responsible for submitting all required reports and notifications relating to the Plan to participants or their beneficiaries, the Internal Revenue Service, and the Department of Labor.

Rules and Decisions. The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate in the administration of the Plan. All rules and decisions of the Plan Administrator shall be applied uniformly and consistently to all employees and participants in similar circumstances. When making a determination or calculation, the Plan Administrator may rely upon all information furnished to the Plan Administrator, including the participant's, former participant's, or beneficiary's current mailing address.

2.3 Appointment of Fiduciaries

All persons or entities who exercise discretionary control or authority over Plan management or assets, and all persons or entities with discretionary authority or responsibility for the administration of the Plan will be considered fiduciaries of the Plan to the extent of such discretionary control or authority.

The Schools hereby appoints each group insurance policy Issuer ("Issuer") and each self-insured plan "Contract Administrator" listed in Appendix A (as amended from time to time) as a fiduciary with such powers as may be necessary to determine the benefits payable under such policy or plan, and to resolve all questions pertaining to the applicability of each policy's or plan's benefit provisions. The decision of a fiduciary on any matter arising under a Component Plan's Benefit Documents, including (but not limited to) questions of Plan construction, interpretation, and administration, and final determinations of eligibility for Plan benefits shall be final, conclusive, and binding on all persons having an interest in or under such Component Plan.

The Schools also hereby intends that each such fiduciary shall be deemed to have complied with the requirements of applicable law in its exercise of its authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

2.4 Refund of Premium

For purposes of fully-insured Component Plans and in accordance with Department of Labor ("DOL") guidance, where any refund of premium (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) is determined to be Plan assets attributable to participant contributions, such assets will be: 1) distributed to current Plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan; or 4) used to pay Plan administrative expenses. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

2.5 Expenses

The Schools shall pay all expenses authorized and incurred by the Plan Administrator in the administration of the Plan, unless by agreement or common practice the Plan Administrator absorbs such expenses.

2.6 Right of Reimbursement from Third Parties

The Plan Administrator may, but is not required to, apply the provisions of this Section 2.6 to the Plan. If a conflict exists with the provisions in the Component Plan's Benefit Documents, the provisions of the Component Plan's Benefit Documents shall control.

The Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount, or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Plan participant to assert a claim to any of the benefits to which the participant or a covered dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from The Schools.

If the Plan should become aware that a Plan participant or covered dependent has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the participant or covered dependents.

Participant Duties and Actions. By participating in the Plan, each Plan participant and covered dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Plan participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Plan participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the participant must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses

arising from circumstances that entitle the Plan participant or covered dependent to any payment, amount or recovery from a third party.

Each Plan participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

2.7 Amendment, Termination, or Merger of Plan

Except as provided in this Section, The Schools (or its duly authorized representative) expressly reserves the unlimited right to amend, terminate, or merge the Plan, in its sole discretion. Any such action shall be adopted by the duly authorized representative of The Schools acting in accordance with its regular duties for The Schools.

The Schools may amend Appendix A to the Plan to accurately reflect the Component Plans offered under the Plan. Any such modification shall not necessitate a formal amendment to this Plan document.

Any amendment, termination or merger of the Plan shall be effective at such date as The Schools shall determine, subject to applicable law. If the Plan is terminated, the rights of the participants and beneficiaries of the Plan are limited to covered charges incurred before the Plan's termination. In connection with the termination, The Schools may establish a deadline by which all claims must be submitted for consideration. Upon termination, any Plan assets, if any, will be used to pay outstanding claims and all expenses of Plan termination.

The right to retiree benefits under the Plan is not a vested benefit and may be amended, changed, modified or terminated by The Schools at any time with respect to scope, cost and availability of such coverage for one or more retirees in any category, provided that no such amendment, change, modification or termination shall affect, at the time adopted, a claim already payable by reason of claim incurred prior to Plan termination.

SECTION 3 – ELIGIBILITY AND PARTICIPATION

3.1 General Eligibility for Benefits

The Schools shall, to the extent permitted by law and by each Component Plan, determine the terms, conditions, or limitations affecting eligibility for Plan benefits. Each eligible employee of The Schools will become a participant in the Plan ("Covered Employee") on the first day after he or she satisfies a Component Plan's eligibility and participation requirements, provided that he or she makes a timely coverage election, properly complies with all applicable enrollment procedures, and makes all contributions required under the Plan at the time and in the manner specified by The Schools and the Component Plan.

If elected by the Covered Employee and permitted under each applicable Component Plan, dependent coverage for his or her eligible spouse and/or eligible child(ren) will begin on the date the Covered Employee's coverage begins, provided that the Covered Employee or the dependent makes a timely coverage election and makes all contributions required at the time and in the manner specified by The Schools and the Component Plan.

Refer to Appendix C of the Plan's Employee Plan Summary ("EPS") to determine the Plan's eligibility and participation requirements for both employees and their dependents. The specific Benefit Documents for each Component Plan also may contain additional eligibility and participation requirements including the terms under which the Covered Employee and his or her dependents may participate in a Component Plan.

3.2 Pre-Age Retiree Eligibility for Medical, Dental and Vision Benefits

Each person who is an eligible retiree and meets The Schools' then-current eligibility requirements for retiree benefits shall be eligible for certain medical, dental, and vision benefits under this Plan.

3.3 Enrollment Procedures

The Schools may from time to time prescribe enrollment procedures that are consistent with the terms of the Plan. Such enrollment procedures may require a Covered Employee's authorization of payroll deductions for all applicable contributions required under the Plan with respect to the Covered Employee and any dependents.

3.4 Special Enrollment and Coverage Rights

HIPAA Special Enrollment Rights. The Plan shall comply with all applicable provisions of HIPAA with regard to the extension of Special Enrollment Periods to an employee, spouse or dependent, as described in Code Section 9801(f), as amended.

Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees. Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving "Full-Time Status" ("ACA-FT") under the ACA's special eligibility rules for variable hour, part-time, and seasonal employees. The Schools shall administer ACA-FT eligibility procedures in a manner that is consistent with the final regulations issued by the Department of Treasury related to the "shared responsibility" provisions of the ACA.

Continuation Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985. Notwithstanding anything in the Plan to the contrary, to the extent required by Code Section 4980B and IRS Regulations thereunder ("COBRA"), a qualified beneficiary who would lose coverage under a Component Plan that is considered a health care plan under COBRA upon the occurrence of a qualifying event (as defined in Code Section 4980B(f)(3)) shall be permitted to continue coverage under such Component Plan(s) by electing to make the applicable contributions, on an after-tax basis, in accordance with procedures established by the Plan Administrator that are consistent with COBRA and any other applicable federal law. The Schools shall provide notice to each Covered Employee and his or her spouse of their rights under COBRA in accordance with applicable law.

For purposes of COBRA coverage, the health benefit options under each Component Plan shall be provided and operated as separate plans governed by separate Benefit Documents.

3.5 Coverage during a Leave of Absence

Subject to the leave policies and procedures adopted by The Schools and to the extent prescribed by law, a Covered Employee may be eligible to continue certain or all Plan benefits for a period of time during an approved leave of absence.

In general, if a Covered Employee goes on an unpaid FMLA, USERRA, or other approved unpaid leave of absence that does not affect eligibility, he or she may, at the Covered Employee's option, continue certain benefits under the Plan for a limited period of time, so long as he or she continues to make any required contribution payments in accordance with The Schools' leave policies and applicable laws.

During a paid leave of absence, a Covered Employee generally will continue coverage under the Plan on the same terms and conditions as required by the Plan Administrator prior to his or her leave of absence so long as the Covered Employee had benefit elections in place prior to the commencement of the leave of absence. The Covered Employee's regular contribution amounts shall continue to be deducted from his or her compensation during such paid leave of absence.

Family and Medical Leave Act ("FMLA")

Notwithstanding any provision to the contrary in this Plan, if a Covered Employee goes on a qualifying unpaid leave under FMLA, The Schools will, to the extent required by FMLA, continue to maintain the Covered Employee's group health plan benefits on the same terms and conditions as if the Covered Employee was still an active employee.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

Notwithstanding any provision herein to the contrary in this Plan, if a Covered Employee goes on a qualifying leave of absence under USERRA, then, to the extent required by USERRA, The Schools will continue his or her Plan coverage on the same terms and conditions as if the Covered Employee was still an active employee.

Applicable State or Municipal Law

The Schools shall permit a participant to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

College Student Medical Leave ("Michelle's Law")

To the extent any Component Plan is a group health plan that requires certification of student status in order to maintain a dependent child's coverage, the Plan shall comply with Michelle's Law. A dependent child enrolled in an institution of higher education who loses his or her student status due to a medically necessary leave of absence shall be allowed to continue such Component Plan coverage for up to one year as measured from the first day of the leave of absence or from the date coverage would otherwise terminate due to the loss of student status, whichever is earlier.

3.6 Termination of Coverage

The coverage of a Plan participant will terminate in accordance with the terms and conditions set forth in the EPS and Benefit Documents for each applicable Component Plan.

SECTION 4 – BENEFITS

4.1 Benefits

For purposes of this Plan, the benefits included hereunder shall be the benefits provided by the Component Plans listed in Appendix A as amended from time to time. The Benefit Documents for each Component Plan contain a complete description of the benefits available and any limitations or exclusions applicable to those benefits.

4.2 Source of Benefits

Benefits under any Component Plan will be provided and paid solely by the Plan pursuant to the terms of the applicable insurance policy or service agreement or applicable self-insured plan document. The Schools neither guarantees nor has any responsibility for the quality of the health care or services provided or the level of benefits paid under any insurance policy or service agreement.

4.3 Coordination of Benefits

The applicable coordination of benefits provisions for the Component Plans are set forth in the benefits documents, contracts, certificate booklets and evidences of coverage for each such Component Plan.

4.4 Coverage Options

The Schools shall have the right to enter into a contract with one or more Issuers and Contract Administrators for the purposes of providing or administering any benefits under the Plan and shall have the right to amend, terminate or replace any such Component Plans. Deductibles, co-payments, co-insurance, and out-of-pocket limits may vary among the coverage options available under the Component Plans, among the different features of a single coverage option, among groups of Plan participants, or in any other manner determined in the discretion of The Schools. In selecting each coverage option, The Schools may rely on tables, appraisals, valuations, projections, opinions or reports furnished by individuals or service providers employed or engaged by The Schools, and may take into account the projected or anticipated costs and expenses relating to the Plan or Component Plan, including administrative costs. Notwithstanding the foregoing, in no event shall the out-of-pocket limit for non-grandfathered group health plans exceed amounts permissible under Public Health Service Act Section 2707(b), as applicable.

4.5 Change in Coverage

The Schools may from time to time prescribe the terms, conditions, and procedures under which a Plan participant may modify or terminate coverage under the Plan or under one or more Component Plans, in addition to those set forth in any applicable Code Section 125 plan describing permissible election changes due to one of the qualifying life events allowed under the Code and/or other federal laws or court orders.

4.6 Funding

The premiums required hereunder, and certain self-insured benefits will be paid solely from the general assets of The Schools. The Schools shall have no obligation, but shall have the right, to insure or self-insure a Component Plan and purchase stop-loss coverage with respect to any self-insured Component Plan. In the event The Schools (and not the Plan) purchases stop-loss insurance that reimburses The Schools for excess claims paid under a self-insured Component Plan, any participant contributions required for such self-insured coverage will not be used to pay the premium for the stop-loss insurance. The stop loss insurance premium will be paid from the general assets of The Schools.

Nothing herein shall be construed to require The Schools to contribute to or under any Component Plan, to continue to sponsor any Component Plan, or to establish a trust, maintain any fund, or segregate any amount for the benefit of any individual covered under the Plan except as specifically required under law or under the terms of a Component Plan.

No Plan participant or any other person shall have any claims against, right to, or security or other interest in, any fund, account or asset of The Schools from which any payment under the Plan may be made.

Notwithstanding anything to the contrary contained herein, participation in the Plan and payment of Plan benefits may be conditioned on Plan participant contributions to the Plan at such time and in such amounts as The Schools establishes. The Schools may require that contributions of an employee and his or her dependents participating in the Plan be made by payroll deduction if such employee is on The Schools' payroll. Payroll deductions may be pre-tax or after-tax as determined by The Schools in its sole discretion.

4.7 Claims and Appeal Procedures

The procedure for obtaining payment of benefits shall be set forth in the Component Plans' Benefit Documents. In the event that such procedures do not exist or fail to comply with applicable federal law and/or implementing regulations, the claims and appeal procedures set forth in the Plan's EPS shall apply.

4.8 Recovery of Overpayment

Any amount paid to any person in excess of the amount to which he or she is entitled under the Plan will be repaid to the Plan or, if applicable, the Issuer, promptly following receipt by the person of a notice of such excess payments. In the event such repayment is not made, such repayment may be made, at the discretion of The Schools or, if applicable, the Issuer, by reducing or suspending any further payments due or future benefits otherwise payable under the Plan to the person and by taking such other or additional actions as may be permitted by applicable law.

4.9 Participant Responsibilities and Unclaimed Benefits

Each Plan participant shall be responsible for providing the Administrator, Claims Administrator and/or The Schools with the current address of the Plan participant, dependents, or beneficiary. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. The Administrator, Claims Administrator, or The Schools shall not have any obligation or duty to locate a person who is or may become entitled to benefits under the Plan except as required by applicable law.

In the event that such a person becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

- Because the current address according to The Schools' records is incorrect,
- Because the Plan participant, dependent or beneficiary fails to respond to the notice sent to the current address according to The Schools' records,
- Because of conflicting claims to such payments, or
- Because of any other reason,

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings.

If, after any amount becomes payable hereunder to a Participant, dependent or beneficiary, and the amount remains unclaimed or any check issued under the Plan remains uncashed after the time period specified and communicated to the claimant by the Plan Administrator (or after 12 months if the time period is not specified by the Plan Administrator) the amount thereof shall be forfeited and shall cease to be a liability of the Plan to the extent the Plan Administrator exercised reasonable care in its attempt to make such payment.

4.10 Additional Health Plan Provisions

The Plan, including the Component Plans, shall comply to the extent applicable with federal and state laws to which they are subject, including, but not limited to:

- Group health plan benefits shall be provided as required by and in conformance with the Patient Protection and Affordable Care Act ("ACA") and the Consolidated Appropriations Act of 2021 ("CAA"), as amended from time to time;
- Mental health benefits shall be provided to the same extent as other medical benefits as required by the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act ("MHPAEA"). To the extent required by applicable law, and to the extent the Plan offers both medical/surgical benefits and mental health/substance abuse benefits and imposes non-quantitative treatment limitations ("NQTL") on such benefits, the Plan shall perform a comparative analyses of the design and application of NQTLs and make such analyses available to applicable state and/or federal authorities in accordance with MHPAEA and the guidance thereunder;
- Certain benefits received in connection with a mastectomy shall be provided as required by the Women's Health and Cancer Rights Act;
- Coverage for childbirth related benefits shall be provided as required by the Newborns' and Mothers' Health Protection Act of 1996;
- Americans with Disabilities Act of 1990 ("ADA");
- State Children's Health Insurance Program, as amended;
- Compliance with the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA"); and,

4.11 Wellness Program

Notwithstanding anything in the Plan to the contrary, to the extent the Plan includes a voluntary wellness program designed to promote the health and wellbeing of covered individuals that includes incentives or rewards for participation, the wellness program shall be administered in accordance with all applicable federal laws, including the ADA, GINA, and HIPAA (as amended by the ACA).

SECTION 5 – THE USE AND DISCLOSURE OF PHI

To the extent that a Component Plan is a group health plan that uses, creates, or has access to protected health information ("PHI") as defined by HIPAA, the following provisions apply. The Schools' HIPAA Privacy and Security Procedures are incorporated by reference herein.

5.1 Health Plans

As permitted by HIPAA, the terms of this Section shall not apply to health information that is:

- Summary health information provided to The Schools for the purposes of obtaining premium bids or modifying the group health plan;
- Information provided to The Schools regarding whether an individual is participating or has enrolled or disenrolled from the plan; or,
- Information provided to The Schools pursuant to an authorization which meets the requirements of the HIPAA Privacy Rules described at 45 C.F.R. Section 164.508.

5.2 Business Associates

The Plan may disclose PHI to its Business Associates (as such term is defined under HIPAA) who have agreed in writing to comply with all applicable HIPAA regulations for purposes related to the administration of the Plan.

5.3 Third Parties with Authorization

With the exception of uses and disclosures of PHI for health care treatment, payment for health care and health care operations, the Plan will disclose PHI to third parties as permitted by HIPAA and upon authorization by the participant, and the information may be used only as described in the authorization. The Plan will not require any participant to complete an authorization as a condition of payment, enrollment, or eligibility for benefits.

5.4 Plan Sponsor

The Plan will disclose PHI to The Schools as plan sponsor of the Plan ("Plan Sponsor") only upon receipt of a certification from the Plan Sponsor that this Plan document contains the limitations and conditions required by HIPAA and contained in this Section.

The Plan Sponsor may use and disclose PHI for the purposes of administration functions that The Schools performs for or on behalf of a group health plan Component Plan to the extent and in accordance with the uses and disclosures permitted by HIPAA and contained in this Section.

5.5 Conditions and Limitations on Use and Disclosure by Plan Sponsor

The Plan Sponsor shall:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Not use or disclose PHI that is genetic information for underwriting purposes;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- Make internal practices, books and records relating to the use and disclosures of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- Report breaches of unsecured PHI as described in Section 5.10;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Ensure adequate separation between the Plan and The Schools as required by 45 C.F.R. Section 164.504(f)(2)(iii) and described in this Plan.

5.6 Organized Health Care Arrangement

The Plan Administrator may intend the Plan to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 C.F.R. Section 160.103) provided by The Schools.

5.7 Access to PHI

In accordance with, and to the extent permitted under, HIPAA, only the following employees or classes of employees may be given access to PHI, including electronic PHI:

- the Privacy Officer;
- the Security Officer (electronic PHI); and,
- staff designated by the Privacy Officer or Security Officer.

The Plan shall ensure that any member of The Schools' workforce who may have access to PHI pursuant to this Section 5.7 is, in a timely manner, properly and routinely trained on The Schools' policies and procedures with respect to PHI, as necessary and appropriate under HIPAA.

5.8 Limitations of PHI Access and Disclosure

The persons described in Section 5.7 may only have access to and use and disclose PHI for Plan administration or operation functions that the Plan Sponsor performs for the Plan. Procedures shall be implemented to ensure that only these designated employees have access to PHI, and even then, that they have access only to the minimum necessary amount of PHI to perform their duties.

The persons described in Section 5.7 may only have access to and use and disclose PHI for Plan administration or operation functions that the Plan Sponsor performs for the Plan. Procedures shall be implemented to ensure that only these designated employees have access to PHI. As required by HIPAA, any access, use or disclosure of PHI shall be limited to the minimum necessary to accomplish the intended purpose of the permitted use or disclosure.

5.9 Security Rules

The Schools further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information, de-identified information or summary health information, which are not subject to these restrictions) on behalf of the Plan, it will:

- Implement administrative, physical, and technical safeguards and security measures that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;

- Ensure that the adequate separation required by 45 CFR § § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent (including subcontractors) to whom it provides such electronic PHI shall agree in writing to implement reasonable and appropriate security measures to protect the PHI; and
- Report to the Plan any security incident of which it becomes aware.

5.10 Breach Notification Rules

In the event of a breach of unsecured PHI by the Plan, the Plan will notify affected individuals, the Department of Health and Human Services, and/or the media in the form and method described under HIPAA.

5.11 HITECH Rules

To the extent that The Schools transmits health information electronically in connection with a Covered Transaction as defined by the HIPAA Privacy Rules, it shall do so in a manner which meets the criteria established by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") and its regulations.

5.12 Nondisclosure of Genetic Information for Underwriting Purposes

The Plan shall not use or disclose PHI that is Genetic Information (as set forth in 45 CFR Section 160.103) for underwriting purposes, as defined in 45 CFR Section 164.502(a)(5)(i).

SECTION 6 – GENERAL PROVISIONS

6.1 Nonassignability

It is a condition of the Plan, and all rights of each person eligible to receive benefits under the Plan shall be subject thereto, that no right or interest of any such person in the Plan shall be assignable or transferable in whole or in part, either directly or indirectly, or by operation of law or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, or bankruptcy, but excluding devolution by death or mental incompetence, and no right or interest of any such person in the Plan shall be liable from, or subject to, any obligation or liability of such person, including claims for alimony or the support of any spouse.

6.2 Employment Noncontractual

The Plan confers no right upon any employee to continue in employment or affect or modify the terms of an employee's employment in any way.

6.3 No Guarantee of Tax Consequences

The Schools makes no commitment or guarantee that any amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for federal or state tax nor that any other favorable tax treatment will apply to or be available to any participant with respect to such amounts. It shall be the obligation of each participant to determine whether each payment under this Plan is excludable from the participant's gross income for federal and state tax purposes, and to notify the Plan Administrator if the participant has reason to believe that any such payment is not so excludable.

6.4 Indemnification of The Schools by Participants

If any participant receives one or more payments or reimbursements under the Plan that are not for an allowable expense, such participant shall indemnify and reimburse The Schools for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursement. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the participant would have owed if the payments or reimbursements that had been made to the participant as regular cash compensation, including the participant's share of any Social Security tax that would have been paid on such compensation, less any additional income and Social Security tax actually paid by the participant.

6.5 Misrepresentation or Fraud

In the event a participant obtains benefits wrongfully due to intentional misrepresentation or fraud, the Plan Administrator, claims administrators, and issuers/contract administrators reserve the right, to the extent permitted by law, to terminate a participant's benefits, deny future benefits, take legal action against such participant, and/or offset from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan.

6.6 Notices

The Plan Administrator shall provide all notices to Plan participants in the manner and form required by federal or state law, including the use of electronic means in conformance with the federal rules governing this method, if permitted. It is the Plan participant's and beneficiary's responsibility to keep the Plan Administrator informed of current addresses.

6.7 Nondiscrimination Rules

This Plan is intended to be nondiscriminatory under applicable provisions of the Code and its regulations. If The Schools determines before or during any Plan Year that the Plan or one of its Component Plans may fail to satisfy

any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, The Schools shall take such reasonable action as The Schools deems appropriate, under rules uniformly applicable to similarly situated covered employees, to ensure compliance with such requirements or limitation, or to avoid adverse tax consequences for highly compensated or key employees. Such action may include, without limitation or the employee's consent, a modification or revocation of the highly compensated or key employee's election or elections.

6.8 Separate Plans

To the extent required to satisfy applicable law, including, but not limited to, the nondiscrimination provisions of the Code, and any privacy and security laws, each coverage level, each group of employees covered by the Plan, and each class of benefits provided under the Plan, may constitute a separate "plan."

6.9 Severability

If any provision of the Plan is held invalid, unenforceable, or inconsistent with any law, regulation or requirement, its invalidity, unenforceability, or inconsistency shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

6.10 Governing Law

The Plan is intended to constitute a welfare benefit plan within the meaning of applicable federal law. To the extent not preempted by federal law, this Plan shall be interpreted and construed in accordance with the laws of the State of Virginia.

6.11 Time Limit and Venue for Legal Actions

The time limit for bringing any lawsuit that arises under or relates to this Plan or a Component Plan is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, such claimant must complete the applicable claims procedure of the Plan or the Component Plan (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the claimant's right to file a lawsuit with respect to the claim.
- In the case of a Component Plan that is self-insured by The Schools, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; and claims against nonfiduciaries) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the Issuer or the Plan shall be determined by the terms of the applicable Component Plan. If the Component Plan does not set forth such a time period, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; and claims against nonfiduciaries) must be brought within one year of the act or omission giving rise to the claim.

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of Virginia.

6.12 Headings and Captions

The headings and captions herein are provided for reference and convenience only and shall not be considered part of the Plan nor be employed in the construction of the Plan.

6.13 Gender and Number

Whenever used in the Plan, words in the masculine gender shall include all gender distinctions, and unless the context otherwise requires, words in the singular shall include the plural, and words in the plural shall include the singular.

IN WITNESS WHEREOF, the undersigned authorized representative has executed this amended and restated Plan document effective as of July 1, 2021, on behalf of Bedford County Public Schools to evidence the adoption of this amended and restated Plan as set forth herein.

For Bedford County Public Schools:

Signature: _____

Name: _____

Title: _____

Date: _____

APPENDIX A

BEDFORD COUNTY PUBLIC SCHOOLS HEALTH AND WELFARE PLAN

Insurance Policy Issuers and Contract Administrators of Component Plans

The Benefit Documents for each of the following Component Plans are incorporated by reference herein. This list is subject to modification from time to time in accordance with Section 2.7 of this Plan document.

Fully-Insured Component Plans	Policy/Group No.	Type of Benefit
All Point 1892 A Graves Mill Road Lynchburg, VA 24502	—	Employee Assistance Program (EAP)
Securian Financial Group, Inc. through Virginia Retirement System (VRS) 400 Robert Street North St. Paul, MN 55101-2098	0029414-G	Basic Life Voluntary Life
Superior Vision 11090 White Rock Road, Suite 175 Rancho Cordova, CA 95670	29687	Vision

Self-Insured Component Plans	Contract No.	Type of Benefit
Anthem 2015 Staples Mill Road Richmond, VA 23230	VA2002	Medical – PPO Medical – HDHP with HSA
Delta Dental of Virginia 4818 Starkey Road Roanoke, VA 24018	600040	Dental – PPO
Health Equity 10800 Midlothian Turnpike, Suite 240 Richmond, VA 23235	BedfordCoS	Health Savings Accounts (HSA)
Optum Rx 2300 Main Street Irvine, CA 92614-6223	PSI1145	Prescription Drug *(for enrollees in one of the Anthem medical plans)*
Virgin Pulse 75 Fountain Street Providence, RI 02902	—	Wellness Program
WageWorks (through Aflac) 1100 Park Place, 4th Floor San Mateo, CA 94403	OJNK2	General Purpose Health FSA Dependent Care FSA