IVY TECH COMMUNITY COLLEGE FLEXIBLE BENEFIT PROGRAM AND SUMMARY

Restated effective as of January 1, 2016

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IVY TECH COMMUNITY COLLEGE
FLEXIBLE BENEFIT PROGRAM AND SUMMARY

PURPOSE OF PROGRAM

The Ivy Tech Community College Flexible Benefit Program and Summary ("Program") allows you to: (A) direct Ivy Tech to pay for your cost of Medical Coverage, Dental Coverage, and/or Vision Coverage with pre-tax dollars; (B) save additional taxes through a Health Flexible Spending Account and/or a Dependent Care Flexible Spending Account; and (C) pay contributions to a Health Savings Account with pre-tax dollars.

If you participate in the Program, you will not pay federal, state, local, or Social Security and Medicare taxes on these pre-tax amounts. Please be aware that this may reduce your future Social Security benefits.

DEFINITIONS

Capitalized words have precise meanings under this Program. The special definitions of the capitalized words are defined here:

"**Accounts**" means a Participant's:

- "**Dependent Care Flexible Spending Account**" which accounts for reimbursement of Dependent Care Expenses.
- "**Health Flexible Spending Account**" which accounts for reimbursement of Qualifying Medical Expenses. A Health Flexible Spending Account means either a General Purpose Health Flexible Spending Account or Limited Purpose Health Flexible Spending Account, as those terms are defined below:
  - "General Purpose Health Flexible Spending Account" means the accounting record maintained under the Program for each electing Participant (other than a Participant who is a participant in a HDHP) who directs amounts to such a General Purpose Health Flexible Spending Account for reimbursement of Qualifying Medical Expenses.
  - "Limited Purpose Health Flexible Spending Account" means the accounting record maintained under the Program for each electing Participant who (i) is enrolled in a HDHP under the Medical Coverage, (ii) is eligible to participate in a Health Savings Account, and (iii) directs amounts to such Limited Purpose Health Flexible Spending Account for reimbursement of dental and vision Qualifying Medical Expenses only.

"Claim Reviewer" means the company that processes reimbursements for the Participant's Accounts.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Dental Coverage" means any coverage available under any group dental plan maintained by Ivy Tech to which you make contributions.

"Dependent Care Reimbursement" means reimbursement for services that, if paid for by you, would be considered employment-related expenses under Code Section 21(b)(2).

"Earned Income" means earned income as defined in Code Section 32(c)(2), but excluding any amounts you paid or Incurred for Dependent Care Reimbursement under the Program. If your Spouse is a full-time student, or is physically or mentally incapable of caring for himself or herself and shares your principal place of abode with you, your Spouse will be deemed to have Earned Income of not less than:

- $250 per month if you have 1 Qualifying Individual, or
- $500 per month if you have 2 or more Qualifying Individuals.

"Eligible Employee" means an Employee employed by Ivy Tech in one of the following employee categories:

- Faculty – employed as a full-time, benefits-eligible faculty member with Ivy Tech who is working at least 80% FTE, generally on a 9 month (academic year) basis for Fall and Spring semesters and a minimum of a 50% summer contract (including summer extended appointments), if enrollment is sufficient.
- Support employee – employed on an hourly basis as a full-time, benefits-eligible support staff with Ivy Tech who are scheduled to work at least 32 hours per week in a position that is typically staffed year-round on an ongoing basis.
- Administrative employee – employed on a salaried basis as a full-time, benefits-eligible administrative employee with Ivy Tech who is regularly scheduled to work at least 32 hours per week in a position that is typically staffed year-round on an ongoing basis.

Notwithstanding the preceding, however, an Eligible Employee will also include an individual who was covered under the Plan as an Eligible Employee on June 30, 2013, so long as he or she remains continuously covered under the Plan and continues to satisfy the definition of Eligible Employee under the terms of the Plan in effect on June 30, 2013.

The term **Eligible Employee** will not include:

- Adjunct faculty.
- Non-benefits eligible part-time support employees who are employed to work a period of 12 months or more and are regularly scheduled to work less than 32 hours per week.
- Non-benefits eligible temporary support employees who are employed to work for less than 12 months per year and do not exceed 1,456 hours worked in a 12 month period.
- Non-benefits eligible part-time administrative employees who are employed to work 12 months or more and are regularly scheduled to work less than 32 hours per week.
- Non-benefits eligible temporary administrative employees who are employed to work less than 12 months per year and do not exceed 1,456 hours worked in a 12 consecutive month period.
- Volunteers with Ivy Tech.
- Any person who is a member of the state or regional Board of Trustees or any committee approved by such Board of Trustees, and is not an Eligible Employee of Ivy Tech.
- Any person employed pursuant to a written agreement which provides that such person will not be eligible for any benefits from Ivy Tech.
- Any leased employees, as defined under Code Section 414(n), or contract employees.
- Any person designated in good faith by Ivy Tech as an independent contractor, regardless of whether such person is later determined to be a common law employee for tax purposes.
- Nonresident aliens who receive no earned income (within the meaning of Code Section 911(d)(2)) from Ivy Tech which constitutes income from sources within the United States under Code Section 861(a)(3).

Notwithstanding the above, *for purposes of participation in the Medical Coverage only*, an Eligible Employee shall include an individual employed by Ivy Tech who is determined to be a Full-Time Employee pursuant to Ivy Tech's policy for determining full-time employment status under Internal Revenue Code Section 4980H, as provided under Appendix A to the Ivy Tech Community College Health and Dental Care Plan, and as amended from time to time.

High Deductible Health Plan/Health Savings Account – Eligibility Under a Health Flexible Spending Account

Notwithstanding the paragraphs above, an Employee who is a participant in a High Deductible Health Plan and a Health Savings Account may be an "Eligible Employee" for purposes of a Health Flexible Spending Account only with respect to a Limited Purpose Health Flexible Spending Account.

"Employee" means any employee of Ivy Tech, except an individual who is a nonresident alien and who receives no earned income (within the meaning of Code Section 911(d)(2)) from Ivy Tech which constitutes income from sources within the United States within the meaning of Code Section 861(a)(3).

"Flex Card" means the card available for point of service direct debiting of the Participant's Health Flexible Spending Account for Qualifying Medical Expenses and/or the Participant's Dependent Care Flexible Spending Account for Dependent Care Expenses.

"FMLA" means the Family and Medical Leave Act of 1993.

"Full-Time Employee" means an individual employed by Ivy Tech an average of at least 30 hours of service per week, pursuant to Ivy Tech's policy for determining full-time employment status under Internal Revenue Code Section 4980H, as provided under Appendix A to the Ivy Tech Community College Health and Dental Care Plan, and as amended from time to time.

"Grace Period" means the two-month period following the end of the prior Program Year with respect to the Dependent Care Flexible Spending Account, and with respect to the 2016 Program Year only. Effective January 1, 2017, no Grace Period applies under the Program.

"Health Savings Account" or **"HSA"** means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary that meets the requirements of Code Section 223(d) and that is recognized by Ivy Tech, in its sole discretion, as eligible to receive salary reduction contributions and Ivy Tech contributions.

"High Deductible Health Plan" or **"HDHP"** means a group health plan sponsored by Ivy Tech that meets the requirements of Code Section 223.

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

"HSA Eligible Employee" means an Eligible Employee who meets the following criteria:

- is a participant in a HDHP;
- is not, while covered under a HDHP, covered under any other health plan that is not a HDHP and which provides coverage for any benefit which is covered under the HDHP (except as provided in Code Section 223(c)(1)(B));
- is not enrolled in Medicare benefits;
- is not claimed as a dependent on another individual's tax return;
- is not covered by a government or military health care plan (*e.g.*, TRICARE); and
- if he or she has a Health Flexible Spending Account under the Plan, such Account is a Limited Purpose Health Flexible Spending Account.

An HSA Eligible Employee who is a participant in a HDHP is eligible to (1) receive Ivy Tech contributions to a HSA in amounts as set forth in Exhibit A, and (2) contribute amounts from his or her compensation as he or she may elect to such HSA and/or a Limited Purpose Health Flexible Spending Account. In all instances, such HSA Eligible Employee is responsible for verifying eligibility to establish and contribute to a Health Savings Account.

"Incurs" or **"Incurred"** refers to the date care or services are provided, *not* the date you are billed or pay for such care or services.

"Ivy Tech" means Ivy Tech Community College of Indiana.

"Medical Coverage" means medical and prescription drug coverage options provided under a group health plan maintained by Ivy Tech, including a High Deductible Health Plan, to which you make contributions. It does not include coverage for qualified long-term care services (as defined in Code Section 7702(B)(c)) or coverage for any product which is advertised, marketed, or offered as long-term care insurance.

"Participant" means an Eligible Employee who has begun participation in the Program and has not subsequently become ineligible to participate.

"Program" means the Ivy Tech Community College Flexible Benefit Program and Summary, as set forth in this document, as amended from time to time.

"Program Year" means the 12-month period beginning each January 1 and ending December 31.

"Qualified Benefit" means the benefits for (1) Medical Coverage, (2) Dental Coverage, and/or (3) Vision Coverage.

"Relative" means your son, daughter, descendant of a son or daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, father, mother, ancestor of a father or mother, stepfather, stepmother, nephew, niece, uncle, aunt, and in-laws.

"Run-Out Period" means, with respect to the Accounts, the 90-day period following the end of a Program Year during which a Participant may submit claims for Qualifying Medical Expenses and Dependent Care Expenses Incurred during that Program Year.

"Special Participant" means an individual who is deemed to have elected coverage under the Program (see **COBRA/RETIREE MEDICAL PREMIUMS** below).

"Spouse" means the person to whom an Eligible Employee is married where the marriage is legally recognized under state law.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

"Vision Coverage" means any coverage available under any group vision plan maintained by Ivy Tech to which you make contributions.

PARTICIPATION IN THE PROGRAM

A. When Participation Begins. You will become a Participant under the Program effective as of the date you are an Eligible Employee and become covered under any Qualified Benefit, provided you properly elect coverage. If you do not meet the definition of an Eligible Employee when you are first hired, and subsequently meet the definition of an Eligible Employee, you will be covered under the Program on the first day you become covered under any Qualified Benefit after you qualify as an Eligible Employee, provided you properly elect coverage under the Program and Qualified Benefit.

B. When Participation Ends. Except as required by COBRA, USERRA, or the section **COBRA/RETIREE MEDICAL PREMIUMS**, you will no longer be a Participant on the earliest to occur of:

- the date the Program terminates;
- the date of your death;
- the date you terminate employment with Ivy Tech;
- the date on which you cease to be an Eligible Employee (except as otherwise required by USERRA or the FMLA);
- with respect to premium deductions for Qualified Benefits, the last day of the pay period in which coverage under the underlying Qualified Benefit ends or COBRA coverage begins;
- the last day of the pay period in which you stop making required contributions;
- as set forth under the Health Flexible Spending Account and Dependent Care Flexible Spending Account sections below; or
- upon your ceasing to be a Participant and not electing to continue coverage under COBRA, or failing to pay premiums as required under COBRA, or, with respect to the Accounts, the end of the Program Year in which the COBRA qualifying event occurs.

C. Reinstatement of Participation by Former Participants. If you return to employment after your termination of employment, you must again satisfy the eligibility requirements and make a new election under the Program for the remainder of the Program Year.

D. Unpaid Leaves of Absence that Qualify under the FMLA.

(1) Stopping Your Contributions. If you take an unpaid FMLA leave of absence, you may stop your contributions for your Qualified Benefits for the duration of the FMLA leave. You may then again elect coverage when you return from unpaid FMLA leave during the same Program Year. To qualify as Dependent Care Expenses, the expenses Incurred must be expenses that allow you and your Spouse (if applicable) to work and to care for certain qualified dependents. Therefore, under most all

circumstances, Dependent Care Expenses that you Incur during a leave of absence would not be considered "qualified" because they are not being Incurred in order for you and your Spouse (if applicable) to work (*i.e.*, in the event of illness). Therefore, you will want to carefully consider this in your decision.

If you stop making contributions to a Health Flexible Spending Account while on unpaid FMLA leave, you will not be entitled to reimbursement of Qualifying Medical Expenses that are Incurred during the period you stopped making contributions to the Health Flexible Spending Account. If you return from FMLA leave during the same Program Year, your coverage level will be reduced by any prior reimbursements made from your Health Flexible Spending Account and you may:

- resume coverage at the same level before the FMLA leave and make up any unpaid contributions or
- resume coverage at a level that is reduced on a *pro rata* basis for the period no contributions were made and resume payments at the level before the leave.

(2) Continuing Your Contributions. If you decide to continue contributions and coverage while on an unpaid FMLA leave, payments will be made on a pay-as-you-go basis under Ivy Tech's existing rules for payments by Employees on an unpaid leave. The regional Human Resources Department will invoice you. In addition, when you return from an unpaid FMLA leave, you may make a new election for the remainder of the Program Year as allowed under the **"Change in Status"** rules below.

AVAILABLE BENEFITS

A. Qualified Benefits. You may elect to reduce your compensation, on a *pre-tax basis* per pay period, by an amount equal to your cost for Qualified Benefits. The cost may change each year. You will be informed of the amount of contributions for benefits. Your share of the benefit costs will be deducted from your pay in equal amounts in the applicable pay periods in a Program Year.

EXAMPLE

Suppose your annual salary is $45,000, you are married and claim one withholding allowance and your Spouse does not work. See what happens if you participate in the Program compared to what happens if you don't:

If You DON'T Participate		If You DO Participate
$45,000.00	Annual Pay	$45,000.00
- N/A	Pre-Tax Payments (under the Program)	-2,000.00
$45,000.00	Taxable Pay	$43,000.00
-742.44	County Withholding	-709.44
-3,600.00	Federal Income Withholding	-3,440.00

-1,530.00	State Tax Withholding	-1,461.96
-2,790.00	Social Security	-2,666.00
-652.50	Medicare	-623.50
-2,000.00	After-Tax Payments (not under the Program)	- N/A
$33,685.00		$34,099.10
		Savings $414.10

You will **not** be required to pay federal, state, or local income taxes, Social Security or Medicare taxes on any pre-tax reduction amounts. In this example you would be contributing the same $2,000, but by making your premium payments on a pre-tax basis, you increase your "spendable" pay by $414.10. This is only an example, your individual tax consequences may be different.

B. Dependent Care and Health Flexible Spending Accounts. You may also elect to reduce your salary, on a *pre-tax basis* per pay period, to participate in the Health Flexible Spending Account (either a General Purpose or Limited Purpose) and/or Dependent Care Flexible Spending Account.

C. Health Savings Accounts. If you are an HSA Eligible Employee (also see page 4), you may elect to reduce your salary, on a *pre-tax basis* per pay period, to pay for contributions to a Health Savings Account. You are also eligible to receive Ivy Tech contributions to an HSA in amounts as set forth in the Exhibit A.

If you are enrolled in or a participant in (i) any Medical Coverage other than a High Deductible Health Plan or (ii) a General Purpose Health Flexible Spending Account, you will **not** be eligible to make or receive contributions to a Health Savings Account at any time during the Program Year.

The annual HSA Ivy Tech contributions will be made to the Health Savings Accounts of each HSA Eligible Employee, in the amount specified by Ivy Tech, in its sole discretion, and set forth in Exhibit A. The annual contribution will be divided into equal contributions over the course of the Program Year. If an HSA Eligible Employee's participation terminates midterm during a Program Year, or if an Employee is not an HSA Eligible Employee for a portion of the Program Year, the annual HSA Ivy Tech contribution will be prorated accordingly. Ivy Tech may modify the annual Ivy Tech contribution amounts and the timing thereof to HSA Eligible Employees, in its sole discretion, at any time.

Ivy Tech contributions to the Health Savings Account will be made in addition to any election made by the HSA Eligible Employee as indicated above. You, and not Ivy Tech, are solely responsible for complying with any applicable contribution limits in effect under the law with respect to the Health Savings Account. Ivy Tech may require such documentation that it deems necessary to confirm that an individual is an HSA Eligible Employee prior to making a contribution to such individual's Health Savings Account.

D. Elections and Election Period.

(1) Initial Election. To make an election for the Program Year in which you *first* become a Participant, you must make an election for (1) Qualified Benefit coverage on a pre-tax basis or, for Program Years before January 1, 2017 only, on a post-tax basis, and/or (2) under the Accounts, and/or (3) under a HSA, by completing the online form *within 31 days* after your hire date.

In order to make or receive contributions to an HSA, you must first establish a HSA that is recognized by Ivy Tech, in its sole discretion, as eligible to receive salary reduction contributions and Ivy Tech contributions (an "eligible HSA"). Your HSA salary reduction election will not be effective until you establish an eligible HSA, and your election will apply on a prospective basis. Notwithstanding, if you are a HSA Eligible Employee, you will receive any Ivy Tech contributions to which you are entitled upon establishing an eligible HSA since your date of eligibility, provided that, effective January 1, 2017, you must establish the eligible HSA within 60 days of becoming a HSA Eligible Employee. Failure to timely establish an eligible HSA will result in forfeiting all Ivy Tech contributions from your date of eligibility until such date that you establish the eligible HSA. In all circumstances, you must establish an eligible HSA by December 31 of a Plan Year in order to make or receive any contributions to the HSA with respect to that Plan Year.

(2) Annual Election. For each Program Year *after* you become a Participant (your "annual enrollment"), Participants will receive open enrollment materials, as will Eligible Employees who have not yet elected coverage. At annual enrollment you may make an election to:

- change your current coverage,
- stop your coverage,
- begin coverage, by completing the annual enrollment process, or
- make no election.

The annual enrollment process will generally take place in the fall of each calendar year, with the new election effective as of January 1st. Your deduction will be effective on the first payroll in the next Program Year.

(3) HSA Election. With respect to elections for Health Savings Accounts only, if you are an **HSA Eligible Employee** (see page 4), you may begin, increase, decrease, or terminate your contributions to the Health Savings Account at any time, by submitting an electronic request via the College's online enrollment system. Your election will be effective upon receipt of a completed election form to the appropriate Regional Human Resources Department with reasonable processing time.

(4) Failure to Elect When First Eligible. If you do not make an election on or before the specified due date when you are first eligible, you will be deemed to have elected to have waived (1) Medical Coverage, Dental Coverage, and Vision Coverage, (2) participation in the Accounts, and (3) employee pre-tax contributions to a HSA.

Except with respect to HSA elections, you must then wait until the next annual enrollment to participate in the Plan, unless you experience a mid-year change in status or other applicable event, as described in Section E. below.

(5) Failure to Elect During Open Enrollment. If you have made an election for coverage for the previous Program Year, and do not make an annual enrollment election, you will be deemed to have (1) re-elected your current Qualified Benefit election which will be carried over to the next Program Year (except that effective January 1, 2017, no post-tax elections will carry forward, so Participants with post-tax elections in effect for the 2016 Program Year will need to actively enroll in Qualified Benefits on a pre-tax basis to continue coverage), (2) waived participation in the Accounts, (3) re-elected your current employee contribution amount to your HSA, which will be carried over to the next Program Year if you are a HSA Eligible Employee. Notwithstanding, you will receive Ivy Tech contributions to a HSA if you are a HSA Eligible Employee, provided that, effective January 1, 2017, you must establish a HSA that is eligible to receive Ivy Tech contributions within 60 days of becoming a HSA Eligible Employee. Failure to timely establish a HSA will result in forfeiting all Ivy Tech contributions from your date of eligibility until such date that you establish the HSA.

E. Changes in Election During the Program Year

Note, you may change or revoke your HSA election at any time during the Program Year. Therefore your HSA election changes are NOT restricted to the events described in this Section.

An election may only be changed as of the beginning of each Program Year if:

- there is a "change in status" or
- another "applicable event" occurs

To change or end an annual election due to a **"change in status"** or another **"applicable event,"** you must submit your request for change to the appropriate regional Human Resources Department within 31 days of the "change in status" or the "applicable event" (60 days in the event of a status change described in the second paragraph under the section entitled **Special Enrollment** on page 14). The election change will be effective the date of the status change or applicable event.

(1) "Change in Status"

You may change *and* make a new election *or* cancel an election to participate in the Program **during the Program Year** if you have a "change in status." The change, election or cancellation must be *on account of* the change in status, *necessary or appropriate as a result* of the status change, and consistent with the terms and conditions of the Qualified Benefit.

"Changes in status" include:

- a change in your legal **marital status**, including
    - divorce,
    - marriage,
    - legal separation or annulment of your marriage;
- a change in the number of your **dependents**, including
    - the death of a Spouse or dependent, or
    - the birth or adoption (or placement for adoption) of your child;
- a change in *your, your Spouse's, or your dependent's* **employment status**, including
    - the termination or commencement of employment,
    - a change from part-time to full-time or full-time to part-time employment,
    - a commencement of or return from an unpaid leave of absence, or
    - a change in worksite that affects eligibility;
- your dependent *satisfying or ceasing to satisfy* the definition of **"dependent"** under the applicable Qualified Benefit coverage, including attainment of certain age or student status; or
- your, your Spouse's, or your dependent's change in the place of **residence** that affects eligibility.

(2) Other Applicable Events

There are other situations in which you can change your election mid-year before the annual open enrollment process. These situations include:

- Significant Change in Cost or Coverage
- Addition or Significant Improvement of Benefit Program Option
- Change in or Loss of Coverage Under Other Employer's Plan
- Special Enrollment
- Entitlement to Medicare or Medicaid
- Medical Child Support Order
- Reduction in Hours of Service
- Enrollment in a Qualified Health Plan

Significant Change in Cost or Coverage (Does ***Not*** Apply to Health Flexible Spending Account Elections).

- *Significant Cost Increase or Decrease.* If you elect to participate in the Program and your cost for Qualified Benefits or Dependent Care Flexible Spending Account coverage significantly increases or decreases during the Program Year, then you may either:

    - make a corresponding increase or decrease in your payments,

    - if there is a significant cost increase, revoke your existing election and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or if not available, drop coverage entirely, or

    - if there is a significant cost decrease, begin participation in the Program and elect the coverage that significantly decreased in cost.

    These changes will be allowed under the Dependent Care Flexible Spending Account **only** if the cost change is required by a dependent care provider who is **not** your Relative.

- *Cost Increase or Decrease*. If you elect to participate in the Program and your cost for Qualified Benefits or Dependent Care Flexible Spending Account coverage increases or decreases during the Program Year, and you are required to make a corresponding change in your premium payments, the Program may make a prospective increase or decrease, as appropriate, in premium payments. These changes will be allowed under the Dependent Care Flexible Spending Account **only** if the cost change is required by a dependent care provider who is **not** your Relative.

- *Coverage is Significantly Reduced (with a Loss of Coverage*). If you, your Spouse, or dependent have a significant reduction in coverage that results in a "loss of coverage," then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or drop such coverage if no other benefit package option providing similar coverage is available under the Program.

- A "loss of coverage" means

    - elimination of a benefit package option (including an HMO ceasing to be available in an area where you reside),

    - loss of all coverage due to hitting a lifetime or annual coverage limit, or

    - a substantial decrease in medical care providers under an option (such as a hospital ceasing to be a member of a preferred provider network

or a substantial decrease in physicians in a preferred provider network).

- *Coverage is Significantly Reduced (without a Loss of Coverage).* If you, your Spouse, or dependent have a significant reduction in coverage but not a "loss of coverage" (for example, a significant increase in deductible, copayment, or out-of-pocket limit), then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another coverage option providing similar coverage. Coverage under the Program is "significantly reduced" only if there is an overall reduction in coverage provided under the Program.

Addition or Significant Improvement of Benefit Program Option Providing Similar Coverage (Does ***Not*** Apply to Health Flexible Spending Account Elections). If Ivy Tech adds a new benefit plan option or other coverage option (or significantly improves an existing benefit option or other coverage option), you may cancel your existing option and elect the newly-added option or the significantly improved option providing similar coverage, on a prospective basis.

EXAMPLE

If Ivy Tech were to offer another health plan option (*e.g.*, a new PPO plan) mid-year, you would be allowed to make a mid-year change to the new option.

Change in or Loss of Coverage Under Other Employer's Plan or Other Group Health Plan (Does ***Not*** Apply to Health Flexible Spending Account Elections). You may make an election change that is on account of and corresponds with a change made under the group health plan of your Spouse, former Spouse, or dependent's employer if:

- the other plan permits Participants to make an election change or
- this Program permits Participants to make an election for a period of coverage that is different from the period of coverage under the other plan.

EXAMPLE

You participate in this Program for the *January 1, 2016* to *December 31, 2016* Program Year for employee-only Medical Coverage. Your Spouse elects coverage under her health plan effective *July 1, 2015* to *June 30, 2016*. In making her new election for the year beginning July 1, 2016 under her plan, she could elect "no coverage" under her plan. This Program would then allow you to elect (mid-year) to cover her under this Program from *July 1, 2016* to *December 31, 2016*.

Loss of Coverage Under Governmental/Educational Group Health Plan (Does ***Not*** Apply to Health Flexible Spending Account). You may make an election to

add Medical Coverage, Dental Coverage, or Vision Coverage for you, your Spouse or dependent if any of you lose coverage under any group medical coverage sponsored by a governmental or educational institution (including a State children's health insurance program, medical program of an Indian Tribal government, a state health benefits risk pool or a foreign government group health plan).

Special Enrollment (Does ***Not*** Apply to Dependent Care Flexible Spending Accounts). If you or your Spouse or dependent are entitled to HIPAA special enrollment under the Program – due to the addition of a new dependent by adoption, placement for adoption, birth, or marriage – you may make a mid-year change to your election consistent with your change in enrollment.

Eligible individuals may also be enrolled in the Program during special enrollment periods if (1) the eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health plan under Title XXI of the Social Security Act, and (2) coverage under such plans is lost due to a loss of eligibility for such coverage. In addition, an eligible individual may be enrolled under the Program if the eligible individual becomes eligible for premium assistance under such Medicaid plan or a state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan), to the extent required under HIPAA.

Entitlement to Medicare or Medicaid (Does ***Not*** Apply to Dependent Care Flexible Spending Accounts). If you, your Spouse, or your dependent are covered under the Program and become entitled to coverage under Medicare or Medicaid (other than coverage solely under the program for distribution of pediatric vaccines), you may change your election to cancel or reduce coverage under the Program for the entitled person. If there is a loss of coverage under Medicare or Medicaid, you may elect to begin or increase coverage under the Program for the affected person.

Court Order/Medical Child Support Order (Does ***Not*** Apply to Dependent Care Flexible Spending Accounts). If you are subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order), you may make a consistent change in your Qualified Benefits election under the Program to either: (1) cover the child or (2) cancel coverage of the child, as applicable.

Reduction in Hours of Service (Applies ***only*** to Medical Coverage Elections). You may make an election to revoke Medical Coverage for you, your Spouse or dependent, on a prospective basis, that relates to your reduction in hours of service. The following criteria must be met:

- your employment status with Ivy Tech was reasonably expected to average at least 30 hours of service per week, and there has been a change in your employment status so that you will reasonably be expected to average less than 30 hours of service per week after the change, although you continue to be eligible for Medical Coverage; and

- you have enrolled, or intend to enroll, yourself (and your Spouse and dependents, if applicable) in another plan that provides "minimum essential coverage" (as defined in Code Section 5000A(f)(1)) that is effective no later than the first day of the second full month following the month that Medical Coverage is revoked.

EXAMPLE

You are employed with Ivy Tech on July 1, 2016 in a full-time position, in which you are reasonably expected to average at least 30 hours of service per week, and you are enrolled in Medical Coverage for employee-only coverage. On September 15, 2016, your employment status changes, such that you will reasonably be expected to average less than 30 hours of service per week. Under Ivy Tech's eligibility terms for Medical Coverage, you remain eligible for coverage for the remainder of the 2016 Plan Year. You may elect to revoke Medical Coverage, on a prospective basis, provided you intend to enroll in another medical plan providing minimum essential coverage that is effective no later than November 1, 2016.

Ivy Tech may require you to certify that you have enrolled, or intend to enroll, yourself, and your Spouse and dependents, if applicable, in other minimum essential coverage.

Enrollment in a Qualified Health Plan (Applies ***only*** to Medical Coverage Elections). You may make an election to revoke Medical Coverage for you, your Spouse or dependent, on a prospective basis, that relates to your (or your Spouse's or dependent's) enrollment in a "Qualified Health Plan" through a health insurance marketplace (a "Marketplace"). The following criteria must be met:

- you are eligible to enroll in a Qualified Health Plan through a Marketplace during either a special enrollment period for such coverage or during the Marketplace's annual open enrollment period; and

- you have enrolled, or intend to enroll, yourself (and your Spouse and dependents, if applicable) in a Qualified Health Plan through a Marketplace for new coverage that is effective no later than the day immediately following the last day that Medical Coverage is revoked.

A "Qualified Health Plan" means a fully-insured health plan that has been certified by the applicable authorities to meet the criteria for certification in a Marketplace and is offered by a health insurance issuer that is appropriately licensed to offer such coverage and meets certain other requirements under federal law.

Ivy Tech may require you to certify that you have enrolled, or intend to enroll, yourself, and your Spouse and dependents, if applicable, in the Qualified Health Plan.

F. Irrevocability of Elections. An election once made will remain in effect until the earliest of:

- the date you are no longer a Participant;
- the effective date of a new election;
- the date the Program or the Qualified Benefit (for purposes of the affected Qualified Benefit) is terminated; or
- the end of the Program Year, unless otherwise provided under E above.

Except as provided above, or as otherwise required by law, an election may be changed only as of the beginning of the Program Year after the election is made.

G. Failure to Make Employee Contributions. Generally, coverage under the Program will end if you do not make the required employee contributions for benefits elected under the Program (except in the case of an unpaid FMLA leave of absence – see **Unpaid Leaves of Absence that Qualify under the FMLA**). In this situation, you may not make a new benefit election under the Program for the remaining portion of that Program Year. If you want to again participate, you must wait until the annual election.

H. Authority of Administrator to Cancel or Revise Certain Elections. To the extent required by Code Section 125, the following nondiscrimination rules will apply:

- the Program will not discriminate in favor of highly compensated employees (as defined by Code Section 125(e)) as to *eligibility* to participate or as to *contributions or benefits*, and
- the benefits provided to key employees (as defined by Code Section 416(i)(1)) will not exceed 25% of the aggregate benefits provided to all Participants.

If Ivy Tech determines that the Program may fail to satisfy any applicable nondiscrimination requirement, Ivy Tech will cancel or revise the elections of key employees and/or highly compensated employees to the extent necessary to satisfy the nondiscrimination requirements.

I. Adjustments to Prevent Discrimination. The Dependent Care Flexible Spending Account will be administered to be in compliance with all applicable nondiscrimination requirements. Ivy Tech may limit the amounts paid or reimbursed to Participants to the extent necessary to satisfy the nondiscrimination requirements.

HEALTH FLEXIBLE SPENDING ACCOUNTS

A. Establishment of Health Flexible Spending Account. You will have a separate Health Flexible Spending Account (which will be either a General Purpose Health Flexible Spending Account or a Limited Purpose Health Flexible Spending Account, as applicable) for each Program Year if you elect benefits under such Account. These Accounts will be maintained for bookkeeping purposes only (with no interest or

earnings credited), and such amounts will remain part of the general assets of Ivy Tech until paid.

B. Maximum Reimbursement to Health Flexible Spending Account. There will be credited to your Health Flexible Spending Account, as of the beginning of the Program Year (or as of the later effective date of your election), the annualized amount which you have elected to have your salary reduced for the Program Year for the reimbursement of Qualifying Medical Expenses. For the 2016 Program Year, the maximum amount that you may elect to have credited to your Health Flexible Spending Account is $2,500. For each Program Year beginning on and after January 1, 2017, you may elect to have credited to your Health Flexible Spending Account the maximum amount permitted by the Internal Revenue Service with respect to that Program Year. If you and your Spouse are both Participants, you may each elect to have the applicable maximum amounts credited to your Health Flexible Spending Account.

EXAMPLE

If you become a participant in the Program on January 1, 2016 and elect to have $2,000 contributed to your Health Flexible Spending Account for the Program Year, you will have $2,000 available to you on January 1, 2016 from which to receive reimbursement.

C. Crediting Your Health Flexible Spending Account. As of the date of any payment, your Health Flexible Spending Account will be debited for Qualifying Medical Expenses Incurred during the Program Year by the amount of the payment, subject to the annualized amount credited to the Health Flexible Spending Account for the Program Year.

D. Qualifying Medical Expenses – General Purpose Health Flexible Spending Account

Qualifying Medical Expenses are certain health, dental, or vision expenses that are Incurred by you or your dependents. The eligible health, dental, and vision expenses are limited to those expenses defined Code Section 213(d), and as allowed under Code Sections 105 and 106(f), and the rulings and Treasury regulations thereunder. A medicine or drug is only a Qualifying Medical Expense if it is prescribed to you or your dependent (Determined without regard to whether the medicine or drug is available without a prescription) or is insulin. For purposes of this definition, your "dependent" means a dependent as defined under the Medical Coverage applicable to you, provided that the dependent is also described in Code Section 105(b)).

Further, the Internal Revenue Service clearly disallows expenses that are merely beneficial to an individual's health as reimbursable expenses for medical care. Also, you or your dependents **must not otherwise be entitled to reimbursement for the expense through insurance or otherwise.** In addition, reimbursement may occur only to the extent that the Qualifying Medical Expense does not include: (1) any **premiums** paid for Medical Coverage, Dental Coverage, or Vision Coverage, (2) qualified long-

term care services as defined in Code Section 7702(B)(c) or (3) coverage provided which is advertised, marketed, or offered as long-term care insurance.

Examples of Qualifying Medical Expenses *could* include:

- custodial care expenses
- hearing aids
- coinsurance amounts
- deductibles
- amounts in excess of the maximums allowed by the medical, dental, or vision plans
- prescription drugs
- over-the-counter (OTC) drugs if they have been prescribed
- insulin (whether or not prescribed)

Examples of expenses that *cannot* be reimbursed include (but are not limited to):

- charges that exceed "reasonable and customary" guidelines
- certain cosmetic surgery
- premiums for health, dental, or vision coverage
- travel expenses
- fees for health clubs
- vitamins
- qualified long-term care services
- any OTC drugs that have not been prescribed (other than insulin)

E. Qualifying Medical Expenses – Limited Purpose Health Flexible Spending Account

If you are enrolled in a High Deductible Health Plan, "Qualifying Medical Expenses" are the same provided in Section D. above, but are limited only to dental or vision expenses that can be reimbursed out of your Limited Purpose Health Flexible Spending Account. This means no medical expenses will be reimbursed.

F. Ceasing to be a Participant with Respect to the Health Flexible Spending Account. If you remain eligible, but fail to make a new election to participate in the Health Flexible Spending Account during open enrollment, you will cease participation in the Health Flexible Spending Account on the last day of the Program Year, except as may be provided under G. below regarding a carryover balance. If you stop being a Participant during a Program Year, you will be entitled to reimbursements from your Health Flexible Spending Account for Qualifying Medical Expenses that were Incurred during the Program Year *before* you stopped being a Participant. In addition, you will not be entitled to reimbursement of Qualifying Medical Expenses for any dependent after the person is no longer a dependent.

Also, to the extent required by COBRA, if you stop being a Participant and agree to pay the premium for COBRA continuation coverage (see page 32), you will be treated as a Participant to the extent required by COBRA, and coverage under the Health Flexible Spending Account will continue as long as such premiums are paid, if applicable, but not beyond the end of the Program Year in which the COBRA qualifying event occurs.

G. Carryover of Unused Health Flexible Spending Account Amounts. If you have a balance remaining in your Health Flexible Spending Account at the end of the Program Year, an amount will be carried over to the immediately following Program Year equal to the lesser of: (1) $500 or (2) the amount remaining in your Account after all of your Qualifying Medical Expenses submitted during the Program Year or within the related Run-Out Period have been reimbursed. This amount is called the "Available Carryover Amount." Any unused amounts in excess of $500 will be forfeited. Your Available Carryover Amount, if any, will carry forward year to year.

The Available Carryover Amount does not reduce the maximum amount that you may elect to have credited to your Health Flexible Spending Account for a Program Year (see Section B. above).

EXAMPLE

You elect to have $2,500 contributed to your Health Flexible Spending Account for Program Year 2016 and Program Year 2017. On December 31, 2016, you have an unused Account balance of $800. On February 1, 2017, you submit claims of $350 for a Qualifying Medical Expense Incurred in 2016. On March 31, 2017 (the end of the 2016 Run-Out-Period), you have an Available Carryover Amount of $450 ($800 - $350). As a result, you have $2,950 for which you may submit claims for the remainder of 2017 ($450 carryover + $2,500 for the 2017 election). For the remainder of 2017, you submit claims in the amount of $2,700, leaving an unused balance of $250 on December 31, 2017. This amount may be carried forward to pay 2018 expenses, to the extent not depleted during the Run-Out Period.

EXAMPLE

Assume the same facts as above, except that you did not submit claims for Qualifying Medical Expenses Incurred in 2016 during the Run-Out Period. In that case, you would have an Available Carryover Amount of $500 for 2017, which is the lesser of $500 and the amount remaining at the end of the Run-Out Period ($800). The excess amount above $500 would be forfeited. You will then have $3,000 for which you may submit claims for the remainder of 2017 ($500 carryover + $2,500 for the 2017 election). For the remainder of 2017, you submit claims in the amount of $2,700, leaving an unused balance of $300 on December 31, 2017. This

amount may be carried forward to pay 2018 expenses, to the extent not depleted during the Run-Out Period.

The Available Carryover Amount will be available to you after the Run Out Period for the prior Program Year to reimburse Qualifying Medical Expenses Incurred in the current Program Year in the same way that your prior year's election could be used, except that if you are currently enrolled in HDHP coverage, your Available Carryover Amount may be used only as a Limited Purpose Health Flexible Spending Account (to reimburse dental and vision expenses only), even if you were enrolled in a General Purpose Health Flexible Spending Account during the prior year. This limitation does not apply, however, if you use your Account balance during the Run-Out Period for reimbursement of claims Incurred in the prior Program Year during which you were enrolled in a General Purpose Health Flexible Spending Account and non-HDHP coverage.

EXAMPLE

You are not enrolled in HDHP coverage in 2016, and you have an unused General Purpose Health Flexible Spending Account balance of $600 remaining on December 31, 2016. For 2017, you enroll in HDHP coverage and elect to contribute $2,500 to a Limited Purpose Health Flexible Spending Account. On January 15, 2017, you Incur a dental expense in the amount of $2,700 and submit the claim for reimbursement. You will be timely reimbursed $2,500 (your full 2017 election), and the remaining $200 will be reimbursed to the extent you have Available Carryover Amount. On February 15, 2017, you submit a medical expense Incurred in 2016 in the amount of $300. ***For purposes of reimbursement for 2016 expenses submitted during the Run-Out Period***, "Qualifying Medical Expenses" are not limited by your current HDHP enrollment, and medical expenses can therefore be reimbursed. At the end of the Run-Out Period (March 31, 2017), you have $300 of Available Carryover Amount ($600 - $300). You will be reimbursed $200 for the excess January claim over the amount elected for 2017. You will then have $100 remaining for which you may submit claims Incurred in 2017. ***For purposes of reimbursement for 2017 expenses***, "Qualifying Medical Expenses" are limited by your current HDHP enrollment to expenses permitted under a Limited Purpose Health Flexible Spending Account (*i.e.*, only dental and vision expenses are eligible for reimbursement).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A. Establishment of Dependent Care Flexible Spending Account. Participants are eligible for a Dependent Care Flexible Spending Account, and will have a separate Dependent Care Flexible Spending Account for each Program Year you elect benefits under the Dependent Care Flexible Spending Account. Dependent Care Flexible Spending Accounts will be maintained for bookkeeping purposes only (with no

interest or earnings credited), and such amounts will remain part of the general assets of Ivy Tech until paid.

B. Reimbursement Amounts. The maximum amount that you may elect to have credited to your Dependent Care Flexible Spending Account for any Program Year is $5,000 (or $2,500 if you are married and do not file a joint federal income tax return for the year). This $5,000 could be less if your Earned Income for the year – or if you are married, the actual or deemed Earned Income of your Spouse for the year – is less than $5,000.

C. Crediting Your Account. Your Dependent Care Flexible Spending Account will be credited, as of *each payroll date* (**not** on an annual basis), with the amount deducted from your compensation. Any expenses paid out of your Dependent Care Flexible Spending Account during the Program Year or within the Grace Period (for Program Year 2016 only) will be reflected in your Account balance. No reimbursement of Dependent Care Expenses will exceed the balance of your Dependent Care Flexible Spending Account at the time of the reimbursement. If you do not have enough in your Dependent Care Flexible Spending Account to pay for Dependent Care Expenses, those Expenses will be held and will be reimbursed at a later date if there is a sufficient balance in your Dependent Care Flexible Spending Account.

EXAMPLE

Assume you elected to have $5,000 contributed to your Dependent Care Flexible Spending Account for the 2016 Program Year. As of April 1, 2016 you have made salary reduction contributions of $1,250 (and have not applied for any reimbursements). Consequently, as of April 1, 2016 you may only file for reimbursement for up to $1,250 (the amount you have actually contributed to the Account).

D. Dependent Care Expenses. **"Dependent Care Expenses"** are expenses that can be reimbursed out of your Dependent Care Flexible Spending Account. To qualify as Dependent Care Expenses, the expenses must:

- allow you and your Spouse to be gainfully employed or to search for gainful employment and
- be for the care of a "Qualifying Individual"

"Qualifying Individual" means:

- your "qualifying child" as defined in section 152(a)(1) of the Code who is under age 13 or
- your dependent (under Code Section 152 but not subsections (b)(1), (b)(2) and (d)(1)(B)) or Spouse who is physically or mentally incapable of caring for himself or herself and who shares a household with you for more than ½ of the year and regularly spends at least 8 hours a day in your household.

A child of divorced or separated parents is a "Qualifying Individual" of the custodial parent if:

- the child is in the custody of one or both parents more than ½ of the year,
- the child receives over ½ of his/her support from his/her parents, and
- the parents are legally divorced or separated.

Note: Your child who is under age 13 or is physically or mentally incapable of caring for himself or herself may be deemed to be a Qualifying Individual even if the former Spouse, and not you, may be entitled to claim a personal exemption deduction with respect to the child.

Additionally, you will not be entitled to reimbursements unless both you and your Spouse work or your Spouse is a full-time student or is mentally or physically unable to care for himself or herself.

Expenses will *not* be reimbursed as Dependent Care Expenses unless their main purpose is to assure the Qualifying Individual's well-being and protection.

Examples of expenses that are *not* considered Dependent Care Expenses include, but are not limited to:

- services not required by your employment, such as baby sitters for leisure activity
- overnight camps
- care provided by a person you claim as a dependent on your federal income tax return
- amounts paid for food, clothing or education
- transportation expenses for a dependent care provider
- care when you are on vacation, holiday, or sick leave
- custodial care
- expenses payable to Relatives

When the expense Incurred includes expenses for other benefits that are incident to and an inseparable part of the care, the full amount of the expense is considered to be for such care.

EXAMPLES

- The full amount paid to a nursery school that a child is enrolled in is considered to be a Dependent Care Expense, even though the school also furnishes lunch and educational services.
- Educational expenses Incurred for a child in the first grade or higher are not treated as eligible Dependent Care Expenses.
- Child care provided by a housekeeper whose services include child care and house cleaning are covered.

- Special rules apply to child care centers. Services provided by a child care center are generally covered. The child care center must be a center that provides dependent care for more than 6 individuals (who do not live at the center on a regular basis during the year) and receive a fee for providing the services. Such centers must comply with all applicable state and local laws and regulations.

You should contact the Claim Reviewer for additional guidance for determining whether a particular expense qualifies as a Dependent Care Expense.

E. Cessation of Participation. If you stop being a Participant during a Program Year or within the Grace Period (applicable to the 2016 Program Year only), you will be entitled to reimbursement of Dependent Care Expenses Incurred during the Program Year or Grace Period (if applicable) in which you ceased to be a Participant, but not to exceed the credit balance in your Dependent Care Flexible Spending Account at the time you cease to be a Participant. Participants who were Participants on the last day of the 2016 Program Year but terminated during the Grace Period are Participants for purposes of the Grace Period.

F. Tax Credit vs. Dependent Care Reimbursement. You are provided a limited **tax** credit for Dependent Care Expenses. As a general rule, the amount of the tax credit is 35% of the Dependent Care Expenses, reduced (but not below 20%) by one percentage point for each $2,000 (or fraction thereof) by which your adjustable gross income for the taxable year exceeds $15,000, up to a maximum credit of $3,000 (for one Qualified Individual) or $6,000 (for two or more Qualified Individuals). **Participation in this Program affects this credit because the dependent care credit is not available for non-taxable reimbursements that you receive from your Dependent Care Flexible Spending Account under this Program.** Under certain circumstances, the credit would be more valuable than the tax savings provided under this Program. ***Therefore, you may wish to consult with your tax advisor before making use of your Dependent Care Flexible Spending Account.***

PROVISIONS APPLICABLE TO THE HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A. Reimbursement of Qualifying Medical Expenses and Dependent Care Expenses. If you make payment by a form other than your Flex Card, you may request reimbursement of Qualifying Medical Expenses and Dependent Care Expenses Incurred during the Program Year (or, with respect to Dependent Care Expenses Incurred during the Grace Period for the 2016 Program Year) by submitting a written claim form to the Claim Reviewer not later than the end of the Run-Out Period for the Program Year in which the Expenses were Incurred. In the event of a loss of eligibility, termination of employment, or retirement, you may submit a written claim form to the Claim Reviewer by no later than 90 days after your loss of eligibility, termination, or retirement. The claim for reimbursement may be made before or after you have paid the Qualifying Medical Expense or the Dependent Care Expense, but not before the Expense has been Incurred.

The written claim form must include:

1. the amount, date, and nature of the Qualifying Medical Expense or Dependent Care Expense;

2. the name of the person, organization, or entity to which the Qualifying Medical Expense was or is to be paid;

3. the name, address, and taxpayer identification number of the person, entity or organization performing the services subject to Dependent Care Expense reimbursement;

4. the name of the person for whom the Qualifying Medical Expense was Incurred and, if the person requesting the benefits is not you, the relationship of the person to you;

5. a written statement (bill or invoice) from the individual delivering the service stating that the Qualifying Medical Expense or Dependent Care Expense has been Incurred and the amount of Expense;

6. a written statement that the Qualifying Medical Expense or Dependent Care Expense has not been reimbursed and is not reimbursable under any other health plan coverage (or if the Qualifying Medical Expense or Dependent Care Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement);

7. a written statement that you are legally obligated to pay for the Qualifying Medical Expense or Dependent Care Expense; and

8. any other information reasonably requested by Ivy Tech or Claim Reviewer.

You must also submit with the claim form all relevant bills, receipts, or other statements with respect to the Expenses, together with any additional documentation that the Claim Reviewer or Ivy Tech may request. If you have a dispute regarding a claim for benefits, see the section labeled **CLAIMS PROCEDURE** starting on page 26. If you submit the written claim form and documentation required and your request for reimbursement is approved, your claim will be paid.

Upon request by the Claim Reviewer, your Flex Card claim must be submitted for review and substantiation on a form supplied by the Claim Reviewer unless the charge is for a copayment or a recurring expense or the charge is substantiated at the point of sale by the provider. All reimbursements requiring substantiation are considered conditional until substantiated. Substantiation of a conditional claim includes submission of the information described above. If you use your Flex Card and the transaction is approved, the Claim Reviewer will automatically debit your Health Flexible Spending Account or Dependent Care Flexible Spending Account, as applicable, for the expenses Incurred. The amount debited will not exceed the amount credited to your Account at the time of the transaction.

In the event a conditional claim is not substantiated or the Program otherwise becomes aware of an improper payment, Ivy Tech and the Claim Reviewer reserve the right to take some or all of the following steps to recover the improper payment:

1. Until the amount of the improper payment is recovered, your Flex Card will be de-activated, and you must request payments or reimbursements of Qualifying Medical Expenses or Dependent Care Expenses by submitting a written claim form to the Claim Reviewer as described above.

2. The Claim Reviewer will notify you of the improper payment and request repayment in an amount equal to the improper payment.

3. If, after the demand for repayment, you fail to repay the amount of the improper charge, Ivy Tech will withhold the amount of the improper charge from your pay or other compensation, to the full extent permitted under applicable law. Your participation in the Program constitutes an agreement to have improper payments resolved by this approach.

4. If any portion of the improper payment remains outstanding after attempts to recover the amount as described above, the Claim Reviewer will offset future reimbursements due under your Health Flexible Spending Account to resolve the improper payment.

5. If the above procedures do not result in full repayment of the improper charge, the Claim Reviewer will refer the claim to Ivy Tech for handling as any other business debt, which may include taxation of the improper payment or other legal action.

Reimbursements will be made at least weekly and can be made by check. The amount of any reimbursement will not exceed the amount credited to your Accounts at the time of the reimbursement. Any dispute regarding a claim for reimbursement will be governed by the **CLAIMS PROCEDURE** starting on page 26.

B. Forfeiture of Unused Amounts.

Except as provided on page 19 under the provisions for **Carryover of Unused Health Flexible Spending Account Amounts**, Federal law requires that the amount credited to your Accounts be used only to reimburse you for Qualifying Medical Expenses or Dependent Care Expenses Incurred **during the Program Year or within the Grace Period (if applicable) for which your election is applicable and only if the Participant applies for reimbursement as set forth on page 23**, with any balance remaining in your Accounts (after all allowable reimbursements for the Program Year have been made during the Run-Out Period) **to be forfeited**. In other words, if you do not use up the amounts in your Health Flexible Spending Account (in excess of any allowable carryover) or Dependent Care Flexible Spending Account by the end of the Program Year or Grace Period (if applicable), *you will lose those amounts. Therefore, it is very important to be conservative when deciding how much you will contribute to these Accounts.*

EXAMPLE

As of November 1, 2017, you have $100 remaining in your Dependent Care Flexible Spending Account. On November 15, 2017 you Incur a Dependent Care Expense equal to $75 and on January 2, 2018 (the next Program Year) you Incur a Dependent Care Expense equal to $50. For the Program Year ending December 31, 2017, you would be reimbursed $75 from your Account, *but would forfeit the remaining unused $25 of your Account*. The remaining $50 expense Incurred on January 2, 2018 would be applied toward your Account for the Program Year starting January 1, 2018, if you had elected one.

Note, a Grace Period applies to the Dependent Care Flexible Spending Account for the 2016 Program Year only, so it is not reflected in the example above for 2017 expenses. Also, under the Medical Care Flexible Spending Account, up to $500 of your unused Account balance may be carried forward to the next Program Year. See page 19 for details.

ADMINISTRATION OF THE PROGRAM

Except as may be otherwise specifically provided in the Program or in any plan providing Qualified Benefits, Ivy Tech will have full, discretionary authority to enable it to carry out its duties under the Program, including, but not limited to, the authority to determine eligibility under the Program to construe and interpret the terms of the Program, to determine all questions of fact or law arising hereunder, and to authorize coverage in a manner which is cost-effective under the Program. Ivy Tech will also have the authority to delegate its authority to others. The designee's actions will be given full force and effect unless determined by Ivy Tech to be contrary to the Program provisions or arbitrary and capricious. All such determinations and interpretations will be final, conclusive, and binding on all persons affected thereby. Ivy Tech will have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Program in such manner and to such extent as it may deem expedient, and subject to the claims provisions of the Program, Ivy Tech will be the sole and final judge of such expediency. Benefits under the Program will be paid only if Ivy Tech and/or its designee decides in its discretion that you are entitled to such benefits.

CLAIMS PROCEDURE

Please see your Medical Coverage, Dental Coverage, and Vision Coverage summaries for claims procedures applicable to those benefits. A brief summary of the claims process for the Program is outlined below. All notifications for claim review, denial, approval and appeal may be done in writing or electronically, unless otherwise designated.

Whenever we refer to "you" in this Article, this will mean any claimant such as you, your Spouse, or your dependent.

A. **Claims for Health Flexible Spending Account**.

(1) **Initial Claim**. Any claim to receive reimbursement for Qualifying Medical Expenses must be filed with the Claim Reviewer within the time period and provide the claim relevant information as required under **Reimbursement of Qualifying Medical Expenses and Dependent Care Expenses** on page 23.

(2) **Initial Review**. When a claim has been properly filed, you will be notified of the approval or denial no later than 30 days after the Claim Reviewer receives the claim, unless the Claim Reviewer needs an extension of 15 days. If additional information is needed, the claimant will have 45 days to provide the information. Thereafter, the claim will be decided within 15 days of the Claim Reviewer receiving this information.

(3) **Initial Denial**. If any claim for reimbursement is partially or wholly denied, you will be given a notice. The notice will include:

- the reasons for the denial;
- reference to the language from the Program that supports the denial decision;
- a description of any additional information needed and why;
- a description of the review procedures and time limits;
- the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the judgment or a statement that an explanation will be provided free, at request.

(4) **Appeal of Claim Denial**. You may appeal a claim denial by filing a written appeal with the Claim Reviewer within 180 days after receipt of the denial. If your request is not timely, the decision of the Claim Reviewer will be final and binding.

Appeals of claims for reimbursement of Qualifying Medical Expenses will be reviewed by the Claim Reviewer who will:

- be the named fiduciary of the Program,
- not be the individual or subordinate of the individual who made the initial determination, and
- not give any weight to the initial determination.

If the appeal is based, in whole or in part, on a medical judgment, the Claim Reviewer will consult with an appropriate health care professional. This person will not be the individual or subordinate of the individual who was consulted in connection with the initial determination. The Claim Reviewer will identify any medical or vocational experts it uses.

(5) **Denial of Appeal**. You will receive notice of the Claim Reviewer's decision on appeal within 60 days after the Claim Reviewer receives the appeal. In

addition, if your claim appeal is denied, you will be given a notice with a statement that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain:

- the reason for the denial;
- reference to the language from the Program that supports the denial decision; and
- the specific internal rule, guideline, or protocol relied on in the denial, with a free copy, at request.

This decision will be final and binding.

B. Claims for Dependent Care Flexible Spending Account.

(1) Initial Claim. Any claim to receive reimbursement of Dependent Care Expenses must be filed with the Claim Reviewer within the time period and provide the claim relevant information as required under **Reimbursement of Qualifying Medical Expenses and Dependent Care Expenses** on page 23.

(2) Initial Review. When a claim has been properly filed, you will be notified of the approval or denial within 90 days after the Claim Reviewer receives the claim, unless special circumstances require an extension of time to process the claim. Written notice of any extension will be furnished to you before the end of the initial 90-day period telling you the circumstances requiring an extension and when a final decision will be reached (which will be no later than 180 days after the claim was filed).

(3) Initial Denial. If any claim for reimbursement is partially or wholly denied, you will be given a notice. The notice will include:

- the reasons for the denial;
- reference to the language from the Program that supports the denial decision;
- a description of any additional information needed and why; and
- a description of the review procedures and time limits.

(4) Appeal of Claim Denial. You may appeal a claim denial by filing a written appeal with the Claim Reviewer within 60 days after you receive notification of the denial. If your request is not timely, the Claim Reviewer's decision will be final and binding.

(5) Denial of Appeal. You will receive notice of the Claim Reviewer's decision on appeal within 60 days after the Claim Reviewer receives the appeal request, unless special circumstances require an extension of time to process the appeal. If so, the Claim Reviewer or its designee will notify you (1) of the extension and (2) when a final decision will be reached (which will not be later than 120 days after receipt of such appeal).

If your claim appeal is denied, you will be given notice with a statement that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information that apply to your claim. The notice will also contain:

- the reasons for the denial; and
- reference to the language from the Program that supports the denial decision.

A decision on review will be final and binding.

C. Claims Provisions Applicable to Both Health Flexible Spending Account and Dependent Care Flexible Spending Account.

(1) Authorized Representative. You may have a representative act on your behalf in pursuing a benefit claim or appeal.

(2) Calculating Time Periods. Claims time periods will begin when a claim or appeal is filed, even if all necessary information is not with the filing. If you fail to provide certain needed information, these time periods may be put on hold. See the Claim Reviewer for details.

(3) Full and Fair Review. You will have reasonable access to, and copies of, all documents, records, and other information relating to your claim, free of charge. You may submit written comments, documents, records, and other information relating to the claim.

If your review request is timely, the review of your denied claim will take into account all comments and documents you submitted about your claim even if that information was not submitted or considered in the initial benefit determination.

(4) Mediation. Claimants and this Program may have other voluntary alternative dispute resolution options, such as mediation. For available options, please contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

(5) Definitions.

- **Denial** means a denial, reduction, termination, or failure to provide or make payment for a benefit, including determinations based on eligibility, and, with respect to health benefits, a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review, or a failure to cover a benefit because it is determined to be experimental or investigational or not medically necessary.
- **Health care professional** means a physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

(6) Exhaustion of Remedies. If you fail to file a request for review of a denial of benefits in whole or in part, as required by these procedures, or fail to follow these procedures, you will have no right to review and no right to bring action, at law or in equity, in any court. The denial of the claim will become final and binding for all purposes.

PROTECTED HEALTH INFORMATION

A. Your Protected Health Information. Federal privacy rules govern how the Program may use and disclose your Protected Health Information and when it may be shared with employees. Protected Health Information ("PHI") generally means information (including demographic information) that:

- identifies an individual (or provides a reasonable basis to believe the information can be used to identify an individual);
- is created or received by a health care provider, a health plan, or certain other entities of the health care industry; and
- relates to the past, present, or future physical or mental health or condition of an individual; information regarding health care provided to an individual; or the past, present, or future payment for an individual's health care.

The Program may use and disclose PHI for purposes related to health care treatment, payment for health care, and for other purposes relating to operating the Program and providing benefits to you.

B. Disclosures of PHI. PHI may need to be disclosed to certain Employees from time to time. The Program may:

- Disclose Summary Health Information to Ivy Tech, if Ivy Tech requests the Summary Health Information for the purpose of:
    - Obtaining premium bids from health plans for providing health insurance coverage under the Program; or
    - Modifying, amending, or terminating the Program.

  "Summary Health Information" generally means health information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom Ivy Tech has provided health benefits under a group health plan. However, identifiers (such as names, addresses, and social security numbers) that can directly link the health information to a particular individual are removed from the information.

- Disclose to Ivy Tech information on whether you or your dependent(s) are participating in the Program, or are enrolled in or have disenrolled from the Program.
- Disclose PHI to Ivy Tech to carry out Program administration functions.

- With your authorization, disclose PHI to Ivy Tech for purposes related to the administration of other employee benefit features and fringe benefits sponsored by Ivy Tech.

In any event, the Program may not:

- Permit a health insurance issuer or HMO to disclose PHI to Ivy Tech except as permitted by this Section;
- Disclose (and may not permit a health insurance issuer or HMO to disclose) PHI to Ivy Tech unless a statement is included in the Program's Notice of Privacy Practices that the Program (or a health insurance issuer or HMO with respect to the Program) may disclose PHI to Ivy Tech; or
- Disclose, without your authorization, PHI to Ivy Tech for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit feature of Ivy Tech.

C. **Uses and Disclosures by Ivy Tech**. When the Program gives Ivy Tech your PHI, Ivy Tech may not use or disclose PHI for employment-related decisions or for its other benefit features without authorization. Ivy Tech may use and disclose PHI without your authorization for Program administrative functions including payment activities and health care operations, or as required by law. If Ivy Tech uses an agent or subcontractor to assist it in performing these activities (such as the Claim Reviewer), the agent's or subcontractor's use and disclosures of PHI will be limited in the same manner as those applicable to Ivy Tech.

Ivy Tech must report any known improper use or disclosure of PHI to the Program. Ivy Tech must also make its records available to federal regulators who are in charge of ensuring that the Program is protecting your PHI. In addition, Ivy Tech must also assist the Program in administering rights that you have to your PHI as described in the Program's notice of privacy practices. When Ivy Tech no longer needs the PHI, it must destroy it or return it to the Program. If return or destruction is not feasible, it must continue to maintain the PHI in accordance with this Article.

Certain employees will have access to your PHI without your authorization. A listing of those authorized employees is set forth in Ivy Tech's HIPAA privacy procedures, as well as under the Ivy Tech Community College Health and Dental Care Plan.

AMENDMENT AND TERMINATION

Ivy Tech, through action of (1) the State Board of Trustees and (2) the President of Ivy Tech or his designee, will have the right, in their sole discretion to amend or modify the Program and any provisions thereof at any time and from time to time to any extent that it may deem advisable. Such modification and amendment will be duly incorporated in writing, which will be signed by the President of Ivy Tech or his or her designee. Any amendment or modification of the Program will be effective as determined by Ivy Tech. Any such amendment may be made retroactively.

Ivy Tech, through action of (1) the State Board of Trustees and (2) the President of Ivy Tech or his designee, will have the right, in their sole discretion, to terminate the Program at any time. Termination of the Program will be effective as determined by Ivy Tech.

CONTINUATION OF COVERAGE

These COBRA continuation provisions, along with the provisions under ***Ceasing to be a Participant with Respect to the Health Flexible Spending Account***, apply to your Health Flexible Spending Account.

A. Qualified Beneficiaries. Only "qualified beneficiaries" may choose to continue coverage. You are a qualified beneficiary if you are covered under the Program under the Health Flexible Spending Account on the day before a "qualifying event" and you are:

- a Participant,
- a Spouse of a Participant, or
- a dependent child of a Participant (including dependents born to or placed for adoption with you during the continuation coverage).

B. Qualifying Events. If one of the following "qualifying events" should occur that would cause you to lose coverage under the Health Flexible Spending Account, you have the right to choose to continue benefit coverage under the Health Flexible Spending Account through COBRA. You are considered to "lose coverage" if you stop being covered under the same terms and conditions as in effect immediately before the qualifying event or have an increase in the premium or contribution that you must pay. These qualifying events are:

- your death;
- your **termination of employment** (other than by reason of gross misconduct) or **reduction of hours** that results in a termination of coverage under the applicable Account;
- your **divorce** or legal separation;
- you becoming entitled to Medicare benefits; or
- your child **ceasing** to be considered a **dependent child**. (In this instance, your child would be eligible for COBRA, but your coverage under the applicable benefit plan would not change).

C. Electing COBRA Coverage. To obtain continuation coverage, a qualified beneficiary must elect it on a form provided by the Claim Reviewer. The period to elect COBRA benefits ends 60 days after the later of:

- the date the qualified beneficiary would lose coverage due to the qualifying event or
- the date the COBRA notice is sent by the Claim Reviewer.

The election form explains the terms and payments for coverage. Your election is considered to be made on the date the Claim Reviewer receives the election form.

D. Paying for COBRA Coverage. The qualified beneficiary is responsible for paying the monthly cost of continuation coverage. This cost is called a "premium." Premiums must be paid each month.

After a qualifying event, the qualified beneficiary will receive a notice specifying:

- the amount of the premium,
- to whom the premium is to be paid, and
- the date each monthly payment is due.

Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium (other than the *initial* one – see below) will be considered "timely" only if it is made ***within 30 days*** after the due date.

The *initial* premium payment, which is for the time period between the date of the qualifying event and the date you elected COBRA coverage, must be made ***within 45 days*** after the date of election. Failure to pay this initial premium by the due date will result in cancellation of coverage back to the initial date coverage would have been terminated.

E. Length of COBRA Coverage. COBRA coverage in the Health Flexible Spending Account will extend only until the end of the Program Year in which the qualified beneficiary's qualifying event occurs.

F. When COBRA Continuation Coverage Ends. COBRA continuation coverage will end *earlier* than the end of the Program Year in which the qualifying event occurs if:

- the first day (including any grace period) for which COBRA premium payments are not made on a timely basis;
- the qualified beneficiary first becomes covered under any other group health plan after electing COBRA coverage. If the other plan contains a limitation with respect to any pre-existing condition that impacts the qualified beneficiary, coverage will not terminate;
- the qualified beneficiary first becomes entitled to benefits under Medicare after electing COBRA coverage;
- Ivy Tech ceases to provide any group health plan to any employee; or
- you cease to be disabled, if your coverage is extended due to the disability.

Coverage may also terminate "for cause" (*e.g.*, the qualified beneficiary submits fraudulent claims). You will be notified, as soon as possible after your continuation coverage is terminating, if such coverage terminates prior to the maximum period set forth above.

G. **Notification Requirements**.

(1) **General Notification to Participant and Spouse.** The Claim Reviewer will give written notice to you and your Spouse of your rights to continuation coverage. This notice will be provided to you and your Spouse not later than the earlier of: (a) 90 days after your coverage begins or (b) the date you would otherwise receive an election form due to a qualifying event (see **Claim Reviewer Notification to Qualified Beneficiary** below).

(2) **Ivy Tech Notification to Claim Reviewer.** In addition, Ivy Tech will notify the Claim Reviewer or its designated representative in the event of your death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits within 30 days after the date of the qualifying event.

(3) **Participant/Qualified Beneficiary Notification to Claim Reviewer.** If you are a Participant or a qualified beneficiary, **you** must notify the Claim Reviewer if you (a) divorce or legally separate from your Spouse, (b) if a child ceases to be a dependent child, or (c) you have a second qualifying event, as soon as possible, but no later than 60 days after the *later* of:

- the date of the qualifying event,
- the date the qualified beneficiary would lose coverage due to such qualifying event, or
- the date you are notified of your notice obligation.

In addition, if you are not entitled to receive continuation coverage, you will be notified of this and will be provided with an explanation as to why you are not entitled to this continuation coverage.

Failure to provide notice within this time frame will result in the loss of your right to elect continuation coverage.

(4) **Procedures for Participant /Qualified Beneficiary Notification**.

Who Are the Individuals Required to Give Notice?

- The qualified beneficiary,
- The Participant, or
- The representative acting on behalf of the Participant or qualified beneficiary.

What Events Require Me to Give Notice?

- A divorce or legal separation of the covered employee from his or her Spouse;
- A child ceasing to be a dependent child under the eligibility requirements of the applicable benefit plan under the Program; or

- A second qualifying event after the qualified beneficiary has become entitled to 18 or 29 months of coverage.

How Am I to Give Notice? The notice that you are required to provide must be in writing and submitted on the form provided by the Claim Reviewer. Oral notice, including notice by telephone, is not acceptable. You must request (either in person, via telephone, or e-mail) a copy of the notice form from the Claim Reviewer. You must complete the notice form (including any attachments described below) and then return the notice form (either by hand-delivery or mail) to the Claim Reviewer by the time period set forth in **Participant/Qualified Beneficiary Notification to Claim Reviewer** above in order to receive COBRA continuation coverage. If mailed, the notice form must be postmarked no later than the last day of the required notice period (as set forth in **Participant/Qualified Beneficiary Notification to Claim Reviewer** above) in order to receive COBRA continuation coverage.

If you do not complete and return this notice form within this required time period, no continuation coverage will be provided to you.

What Information Will You Need to Provide on Notice Form? On the notice form you must indicate the name of the Program, the name and address of the Participant under the Program, the name(s) and address(es) of any qualified beneficiary(ies), the qualifying event or disability information (whichever is applicable), and the date of the qualifying event or necessary disability information (whichever is applicable). If the qualifying event is *a divorce*, you must attach a copy of the divorce decree to the notice form. Your notice of *disability* determination or cessation must attach a copy of the Social Security Administration's determination.

(5) Claim Reviewer Notification to Qualified Beneficiary. Upon notification of a qualifying event, you and your dependents will be notified by the Claim Reviewer of your right to elect continuation coverage within 14 days of the date its designee received notice of the qualifying events.

In addition, if you are not entitled to receive continuation coverage, you will be notified of this and will be provided with an explanation as to why you are not entitled to this continuation coverage.

Any notification to a qualified beneficiary who is the Spouse of the Participant will be treated as a notification to all other qualified beneficiaries residing with the Spouse when notification is made.

H. About the Coverage Provided Under COBRA. The COBRA coverage provided will be identical to the coverage provided to similarly situated persons who have not experienced a qualifying event. If coverage is modified for any group of similarly situated beneficiaries, coverage will also be modified in the same manner for all qualified beneficiaries.

COBRA/RETIREE PREMIUMS

Any contributions received by Ivy Tech from a former Employee of Ivy Tech (and/or his or her applicable dependents) (referred to as "Special Participants") for retiree medical or dental or COBRA coverage, will be made on an after-tax basis under this Program.

Elections for such coverage will remain in place until the *earliest* of:

- the date the Program ends;
- the date the underlying coverage ends or is exhausted for the Special Participant; or
- the date the Special Participant revokes or stops coverage or fails to make timely contributions for coverage.

While coverage is in force, the Special Participant may make changes in the coverage as allowed under the underlying coverage, but only if:

- the change is on account of a "change in status" or "applicable event" (as defined on page 10);
- such change is necessary or appropriate as a result of the change in status or applicable event (pursuant to the retiree provisions of such program), or the COBRA continuation coverage requirements; and
- such change must be requested by the Special Participant within 31 days after the change in status or "applicable event", to be effective on the later of the status change or "applicable event" or the request for it.

A Special Participant will not be considered a Participant for any other purpose of this Program.

MISCELLANEOUS

A. Report to Participants on or before January 31 of Each Year. On or before January 31 of each Program Year, Ivy Tech will furnish to each Participant who has received Dependent Care Reimbursement during the prior Program Year a written statement (on the Form W-2) showing the amount of all Dependent Care Reimbursement paid to or on behalf of the Participant during the prior Program Year.

B. Taxes or Penalties. If there are any taxes or penalties payable by Ivy Tech on your behalf, such taxes or penalties will be payable by you to the extent such taxes would have been originally payable by you had this Program not been in existence.

C. No Guarantee of Tax Consequences. Ivy Tech does not make any commitment or guarantee that any amounts paid to you or for your benefit under the Program will be excludable from your gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment will apply to or be available to you. It will be your obligation to determine

whether payment under the Program is excludable from your gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify Ivy Tech if you have reason to believe that any such payment is not excludable.

D. Indemnification Of Ivy Tech By Participants. If you receive one or more reimbursements under your Dependent Care Flexible Spending Account that are not for Dependent Care Expenses or under your Health Flexible Spending Account that are not for Qualifying Medical Expenses, you will indemnify and reimburse Ivy Tech for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from the reimbursements. However, your indemnification and reimbursement will not exceed the amount of additional federal, state, or local income tax that you would have owed if the reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by you.

E. Eligibility for Medicaid Benefits. Benefits will be paid in accordance with any assignment of rights made by or on your behalf as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, your or your dependent's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The state will have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Program has a legal liability to make such payment.

F. Federal Laws. The Program will comply with the Newborns' and Mothers' Health Protection Act of 1996, the Women's Health and Cancer Rights Act of 1998, the Mental Health Parity Act of 1996, the FMLA, and USERRA.

G. HIPAA Compliance. To the extent required under HIPAA, the Program will comply with the requirements under HIPAA including:

- compliance with certain special enrollment periods;
- nondiscrimination benefits requirements; and
- privacy and security requirements (as described above) to the extent required and to the extent not otherwise inconsistent with the requirements under Code Section 125 and any regulations issued thereunder.

H. Limitation of Rights and Obligations. Neither the establishment nor maintenance of the Program nor any amendment thereof, nor any act or omission under the Program or resulting from the operation of the Program will be construed:

(1) as conferring upon you, your dependent, your beneficiary, or any other person a right or claim against Ivy Tech or the Claim Reviewer, except to the extent that such right or claim will be specifically expressed or provided in the Program or provided under ERISA;

(2) as creating any responsibility or liability of Ivy Tech or the Claim Reviewer for the validity or effect of the Program;

(3) as a contract or agreement between Ivy Tech and you or other person;

(4) as being consideration for, or an inducement or condition of, employment of any Participant or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of any Ivy Tech or you or any other person to continue or terminate the employment relationship at any time; or

(5) as to give you or any other person, the right to be retained in the service of any Ivy Tech or to interfere with the right of any Ivy Tech to discharge you or any other person at any time.

I. **Forms and Proofs.** You must complete all forms and furnish all proofs, receipts, and releases as may be required by any Ivy Tech or the Claim Reviewer.

J. **Assignment of Benefits.** Except as provided pursuant to a qualified medical child support order, no benefit under the Program prior to actual receipt thereof by you, your dependent, or your beneficiary, will be subject to any debt, liability, contract, engagement, or tort of you, your dependent, or your beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law.

K. **Misrepresentation.** If you or your beneficiary make a material misrepresentation in making application for coverage or receipt of benefits, your coverage will be null and void for all purposes.

L. **Counterparts.** The Program may be executed in any number of counterparts, each of which will be deemed to be an original. All counterparts will constitute but one and the same instrument and will be evidenced by any one counterpart.

M. **Notice.** Any notice given under the Program will be sufficient if given to Ivy Tech or Claim Reviewer, when addressed to its office; or if given to you, when addressed to you at your address as it appears in the records of Ivy Tech or the Claim Reviewer.

N. **Disclaimer of Liability.** Nothing contained herein will confer upon you any claim, right, or cause of action, either at law or at equity, against the Program, Claim Reviewer, or Ivy Tech for the acts or omissions of any provider of services or supplies for any benefits provided under the Program.

O. **Right of Recovery.** If Ivy Tech or the Claim Reviewer makes any payment that according to the terms of the Program should not have been made, it may recover that incorrect payment, whether or not it was made due to Ivy Tech's or the Claim

Reviewer's own error, from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made directly to you, Ivy Tech or the Claim Reviewer may deduct it when making future payments directly to you.

P. Legal Counsel. Ivy Tech and/or its designee may from time to time consult with counsel, who may be counsel for Ivy Tech and will be fully protected in acting upon the advice of such counsel.

Q. Evidence of Action. All orders, requests, and instructions to Ivy Tech or its designee by any duly authorized representative, will be in writing and Ivy Tech or its designee will act and will be fully protected in acting in accordance with such orders, requests, and instructions.

R. Protective Clause. Ivy Tech will not be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

S. Receipt and Release. Any payments to you will, to the extent thereof, be in full satisfaction of your claim being paid and Ivy Tech may condition payment on your delivery of the duly executed receipt and release in such form as may be determined by Ivy Tech.

T. Benefits Solely from General Assets. Except as may otherwise be required by law:

(1) the benefits provided hereunder will be paid solely from the general assets of Ivy Tech;

(2) nothing herein will be construed to require Ivy Tech to maintain any fund or segregate any amount for your benefit; and

(3) no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account, or asset of Ivy Tech from which any payment under the Program may be made.

U. Legal Actions. If Ivy Tech is made a party to any legal action regarding the Program, any and all costs and expenses, including reasonable attorneys' fees, Incurred by Ivy Tech in connection with such proceeding will be paid by Ivy Tech.

V. Reliance. Ivy Tech will not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by Ivy Tech to be genuine or to be executed or sent by an authorized person.

W. Qualified Medical Child Support Orders. The Program will provide benefits in accordance with the applicable requirements of a qualified medical child support order, as required by state and federal law, received by the Program. If the Program receives a medical child support order, Ivy Tech will promptly notify you, and

each of your children identified in the order, of the receipt of such order and the Program's procedures for determining whether the order is a qualified medical child support order. Within a reasonable time after receipt of such order, Ivy Tech will determine whether the order is a qualified medical child support order and notify you and your children involved of the determination. If the order is a National Medical Support Notice, Ivy Tech will determine whether the notice is appropriately completed, complete Part A or Part B of the notice, as applicable, and return the Part(s) to the issuing agency. Ivy Tech will establish written procedures in accordance with state and federal law to determine whether a medical child support order received by the Program is a qualified medical child support order under state and federal law.

X. Participant Incapacitation. When you are under legal disability or, in Ivy Tech's opinion, is in any way incapacitated so as to be unable to manage your affairs, Ivy Tech may cause your benefits to be paid to your legal representative for your benefit. The payment of benefits will completely discharge the liability of Ivy Tech for the benefits.

Y. Participant Death. In the event of your death, your Spouse (or, if none, your executor or administrator) may apply on your behalf for reimbursement of Qualifying Medical Expenses or Dependent Care Expenses as applicable. The payment of benefits will completely discharge the liability of Ivy Tech for the benefits. The disposition and taxation of any amounts remaining in your Health Savings Account upon your death will be determined based on whom you have designated as your beneficiary of the HSA and is not the responsibility of Ivy Tech.

Z. Rules of Interpretation. The Program is to be administered consistent with Code Section 125. The Health Flexible Spending Account is to comply with the requirements of Code Sections 105, 106, and 4980B and the Dependent Care Flexible Spending Account is to comply with the requirements of Code Section 129. Eligibility to make contributions to a Health Savings Account will be interpreted to be in compliance with Code Section 223.

AA. Review of Election. You are responsible for reviewing your benefit selection and payroll deduction amount when selecting to participate in this Program. You must review this election before the effective date of your election. As of the effective date of the election, such election may not be changed for the remainder of the Program Year, except as otherwise provided in this Program.

BB. Entire Program. The Program document and the documents incorporated by reference herein will constitute the only legally governing documents for the Program. All statements made by Ivy Tech will be deemed representations and not warranties. No oral statement or other communication will void or reduce coverage under the Program, or amend or modify the terms of the Program, or be used in defense to a claim, unless in writing signed by Ivy Tech.

IN WITNESS WHEREOF, Ivy Tech has caused this instrument to be executed by its duly authorized officers this 31st day of March, 2017.

"IVY TECH"

IVY TECH COMMUNITY COLLEGE

By: Julie Lorton-Rowland

Printed: Julie Lorton-Rowland

Title VP for Human Resources

EXHIBIT A

IVY TECH HSA CONTRIBUTIONS

Effective as of January 1, 2016

Scope	24 Pays	18 Pays
Employee	$31.25	$41.67
Employee/Child(ren)	$62.42	$83.22
Employee/Spouse	$70.00	$93.34
Employee/Family	$70.00	$93.34

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FIRST AMENDMENT AND SUMMARY OF CHANGES TO THE IVY TECH COMMUNITY COLLEGE FLEXIBLE BENEFIT PROGRAM AND SUMMARY

The Ivy Tech Community College Flexible Benefit Program and Summary ("Program") serves as both the Plan document and Summary of the Program. The Program was most recently amended and restated in its entirety, effective January 1, 2016.

Ivy Tech Community College of Indiana ("Ivy Tech") reserved the right to amend the Program pursuant to relevant provisions under the "Amendment and Termination" section of the Program. Pursuant to that section, the Program is now being amended as described below, generally effective as of January 1, 2020 unless otherwise stated.

This First Amendment and Summary is now a part of the Program and should be included with your copy of the Program. If you need a copy of the Program, please contact Ivy Tech.

1. **Section D. Qualifying Medical Expenses – General Purpose Health Flexible Spending Account**, beginning on page 17, is revised as follows:

> **D. Qualifying Medical Expenses – General Purpose Health Flexible Spending Account**
>
> **Qualifying Medical Expenses** are certain health, dental, or vision expenses that are Incurred by you or your dependents. The eligible health, dental, and vision expenses are limited to those expenses defined under Code Section 213(d), and as allowed under Code Sections 105 and 106(f), and the rulings and Treasury regulations thereunder. For purposes of this definition, your "dependent" means a dependent as defined under the Medical Coverage applicable to you, provided that the dependent is also described in Code Section 105(b)).
>
> The Internal Revenue Service disallows expenses that are merely beneficial to an individual's health as reimbursable expenses for medical care. Also, you or your dependents **must not otherwise be entitled to reimbursement for the expense through insurance or otherwise.** In addition, reimbursement may occur only to the extent that the Qualifying Medical Expense does not include: (1) any **premiums** paid for Medical Coverage, Dental Coverage, or Vision Coverage, (2) qualified long-term care services as defined in Code Section 7702(B)(c) or (3) coverage provided which is advertised, marketed, or offered as long-term care insurance.
>
> **Examples of Qualifying Medical Expenses *could include***:
>
> - custodial care expenses

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- hearing aids
- coinsurance amounts
- deductibles
- amounts in excess of the maximums allowed by the medical, dental, or vision plans
- prescription drugs and over-the-counter drugs
- insulin
- menstrual products

Qualifying Medical Expenses *do not include*:

- charges that exceed "reasonable and customary" guidelines
- certain cosmetic surgery
- premiums for health, dental, or vision coverage
- travel expenses
- fees for health clubs
- vitamins
- qualified long-term care services

2. **Section F. <u>Ceasing to be a Participant with Respect to the Health Flexible Spending Account</u>**, located on page 18, is revised as follows:

F. <u>Ceasing to be a Participant with Respect to the Health Flexible Spending Account</u>.

If you remain an Eligible Employee for the entire Program Year, but fail to make a new election to participate in the Health Flexible Spending Account during open enrollment, you will cease participation in the Health Flexible Spending Account on the last day of the Program Year, except as may be provided under G. below regarding a carryover balance.

If you stop being a Participant during a Program Year because you either terminate employment or cease to be an Eligible Employee, you will be entitled to reimbursements from your Health Flexible Spending Account for Qualifying Medical Expenses that were Incurred during the Program Year *before* you stopped being a Participant (except as may be provided under COBRA).

In addition, you will not be entitled to reimbursement of Qualifying Medical Expenses Incurred by any dependent after the person is no longer a dependent (except as may be provided under COBRA).

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3. **Section G. Carryover of Unused Health Flexible Spending Account Amounts**, located on page 19, is revised as follows:

> **G. Carryover of Unused Health Flexible Spending Account Amounts.** If you have a balance remaining in your Health Flexible Spending Account at the end of the Program Year, an amount will be carried over to the immediately following Program Year equal to the lesser of: (1) $500 ($550 beginning with Program Year 2020) or (2) the amount remaining in your Account after all of your Qualifying Medical Expenses submitted during the Program Year or within the related Run-Out Period have been reimbursed. This amount is called the "Available Carryover Amount." Any unused amounts in excess of $550 will be forfeited. Your Available Carryover Amount, if any, will carry forward year to year.

4. A new **Section H. Mid-Year Elections to Reduce or Suspend Contributions to the Health Flexible Spending Account**, is added on page 20 as follows:

> **H. Mid-Year Elections to Reduce or Suspend Contributions to the Health Flexible Spending Account.** If you reduce or suspend your contributions to the Health Flexible Spending Account prospectively during a Program Year pursuant to a mid-year election change, the following applies:
>
> - Your new election may not reduce your annual election to an amount that is less than reimbursements received for Qualifying Medical Expenses at the time of the election change; and
>
> - You will only be entitled to continue to receive reimbursements from your Health Flexible Spending Account for Qualifying Medical Expenses that were Incurred during the Program Year to the extent that your new annual election exceeds your reimbursements at the time of the election change.
>
> **EXAMPLE ONE:** You elect to have $2,400 contributed to your Health Flexible Spending Account for the January 1, 2020 to December 31, 2020 Program Year. You are reimbursed for $300 in Qualifying Medical Expenses on March 15, 2020. In connection with a change in status event, you elect to suspend your Health Flexible Spending Account election, effective July 1, 2020. Your new annual election is $1,200 ($1,200 contributed from January through June and $0 contributed from July through December). As of July 1, 2020, you are entitled to $900 in reimbursements from your Health Flexible Spending Account for Qualifying Medical Expenses that are Incurred at any point in the 2020

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Program Year ($1,200 in contributions less $300 in prior reimbursements).

EXAMPLE TWO:

Assume the same facts as above, except that by July 1, 2020, you had received $1,500 in prior reimbursements. In that case, you would not be permitted to reduce your contributions mid-year to an amount that is less than $300, because your total contributions ($1,200 contributed from January through June and $300 contributed from July through December) cannot be less than your prior reimbursements ($1,500).

4. **Section E. Cessation of Participation**, located on page 23, is renamed and revised as follows:

E. Ceasing to be a Participant with Respect to the Dependent Care Flexible Spending Account.

If you remain an Eligible Employee for the entire Program Year, but fail to make a new election to participate in the Dependent Care Flexible Spending Account during open enrollment, you will cease participation in the Dependent Care Flexible Spending Account on the last day of the Program Year.

If you stop being a Participant during a Program Year because you either terminate employment or cease to be an Eligible Employee, you will be entitled to reimbursement of Dependent Care Expenses Incurred during the remainder of the Program Year in which you ceased to be a Participant, but not to exceed the credit balance in your Dependent Care Flexible Spending Account at the time you cease to be a Participant.

5. A new **Section G. Mid-Year Elections to Reduce or Suspend Contributions to the Dependent Care Flexible Spending Account**, is added on page 23 as follows:

G. Mid-Year Elections to Reduce or Suspend Contributions to the Dependent Care Flexible Spending Account. If you reduce or suspend your contributions to the Dependent Care Flexible Spending Account prospectively during a Program Year pursuant to a mid-year election change, you will be entitled to reimbursement of Dependent Care Expenses Incurred for the remainder of the Program Year, but not to exceed the credit balance in your Dependent Care Flexible Spending Account at the time of your election change, plus your additional (reduced) contributions, if any. No reimbursement of Dependent Care Expenses will exceed the balance of your Dependent Care Flexible Spending Account at the time of the reimbursement.

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EXAMPLE:

You elect to have $2,400 contributed to your Dependent Care Flexible Spending Account for the January 1, 2020 to December 31, 2020 Program Year. As of July 1, 2020, you have made $1,200 in contributions and received $500 in reimbursements for Dependent Care Expenses, leaving a balance of $700. In connection with a change in status event, you elect to suspend your Dependent Care Spending Account election, effective July 1, 2020. You are entitled to reimbursement of Dependent Care Expenses Incurred during the Program Year, not to exceed the credit balance in your Dependent Care Flexible Spending Account at the time you suspended your contributions ($700).

6. **Section A. Reimbursement of Qualifying Medical Expenses and Dependent Care Expenses**, located on page 23, is revised as follows:

A. Reimbursement of Qualifying Medical Expenses and Dependent Care Expenses. If you make payment by a form other than your Flex Card, you may request reimbursement of Qualifying Medical Expenses and Dependent Care Expenses Incurred during the Program Year by submitting a written claim form to the Claim Reviewer not later than the end of the Run-Out Period for the Program Year in which the Expenses were Incurred. With respect to the Health Flexible Spending Account only, in the event of a loss of eligibility, termination of employment, or retirement during the Program Year, you must submit a written claim form to the Claim Reviewer by no later than 90 days after your loss of eligibility, termination, or retirement. A claim for reimbursement may be made before or after you have paid the Qualifying Medical Expense or the Dependent Care Expense, but not before the Expense has been Incurred.

7. The final paragraph of **Section B. Forfeiture of Unused Amounts**, found on page 26, is revised as follows:

Note, a Grace Period applies to the Dependent Care Flexible Spending Account for the 2016 Program Year only, so it is not reflected in the example above for 2017 expenses. Also, under the Medical Care Flexible Spending Account, up to $500 ($550 beginning with Program Year 2020) of your unused Account balance may be carried forward to the next Program Year. See page 19 for details.

8. A COVID-19 Addendum is added to the end of the Program to permit special mid-year election changes and deadline extensions for Program Year 2020, in the same form as attached.

9. In all other respects, the Program shall remain unchanged.

This First Amendment and Summary is executed as of the date and year written below.

IVY TECH COMMUNITY COLLEGE OF INDIANA

By: DocuSigned by: Julie Lorton-Rowland 02CFA0DAAE4F48D...

Print: Julie Lorton-Rowland

Title: Sr. VP Human Resources

Date: 6/29/2020 | 2:06 PM EDT

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COVID-19 ADDENDUM
TO THE
IVY TECH COMMUNITY COLLEGE
FLEXIBLE BENEFIT PROGRAM AND SUMMARY

Due to the national public health emergency related to COVID-19, the federal government has issued several temporary relief provisions that impact employee benefit plans. This Addendum outlines the terms of these relief provisions under the Program.

Mid-Year Election Changes for Program Year 2020

Limited Opportunity for Election Changes During Program Year 2020 (Applies ***only*** to Health Flexible Spending Account and Dependent Care Flexible Spending Account Elections for 2020 Participants). Effective for the period beginning May 25, 2020 and ending October 23, 2020, if you have a Health Flexible Spending Account election in place and/or if you have a Dependent Care Flexible Spending Account election in place for the 2020 Program Year, you may make the following changes with respect to those election(s):

- You may make up to **two** separate elections to *increase*, *decrease*, or *stop* contributions to your Health Flexible Spending Account on a prospective basis.

- You may make up to **two** separate elections to *increase*, *decrease*, or *stop* contributions to your Dependent Care Flexible Spending Account on a prospective basis.

You may **not** seek a refund of Health Flexible Spending Account and/or Dependent Care Flexible Spending Account contributions that have already been made. In addition, a new annual election to decrease a Health Flexible Spending Account election cannot be less than any amount to date that had been reimbursed from the Account (or, in other words, the decreased annual election amount must be at least equal to prior 2020 reimbursements).

EXAMPLE 1:

You made an annual election to contribute $2,400 to a Health Flexible Spending Account for the January 1, 2020 to December 31, 2020 Program Year. As of May 31, 2020, you have made $1,000 in contributions and you have received $1,500 in reimbursements for Qualifying Medical Expenses. You may choose to decrease your Health Flexible Spending Account contributions, effective June 1, 2020, to equal $500 for the remainder of the 2020 Program Year, so that your new annual election will be $1,500 [$1,000 for January to May plus $500 for June to December]. In this case, you will not be eligible to receive additional reimbursements for Qualifying Medical Expenses for the remainder of the Program Year because you have already received $1,500 in reimbursements.

EXAMPLE 2:

Assume the same facts as Example 1, except that you have only received $300 in reimbursements for Qualifying Medical Expenses as of May 31, 2020. You

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may choose to stop your Health Flexible Spending Account contributions, effective June 1, 2020, and you will remain eligible to receive $700 in reimbursements for the remainder of the Program Year [$1,000 in contributions less $300 in reimbursements].

An election change under this provision must be received by no later than October 23, 2020. The election will be effective as soon as administratively feasible after receipt of your completed election (typically, the first pay check after you make your election).

Extension of Special Enrollment Period

Extension of Special Enrollment Period (Applies ***only*** to Medical Coverage Elections). If you and/or your Spouse or dependents experienced a special enrollment event on or after January 31, 2020 (January 1, 2020 if the event was related to Medicare or CHIP), and you have not enrolled yourself and/or your Spouse or dependents in Medical Coverage, you have additional time to enroll in Medical Coverage, even if the normal deadline has passed. Under the Program, you may submit your request for special enrollment within the following time periods:

- Within 31 days of the loss of other coverage or the addition of a new dependent due to marriage, birth, or adoption (or placement for adoption), or

- Within 60 days of the loss of eligibility for Medicare or CHIP, or eligibility for premium assistance under Medicare or CHIP.

In determining your deadline to enroll, the period beginning March 1, 2020, and ending 60 days after the end of the National Emergency related to Covid-19 (the "Outbreak Period"), does not count in determining your special enrollment period. The end date of the National Emergency has not yet been announced.

EXAMPLE:

Assume that the National Emergency ends May 31, 2020, such that the Outbreak Period ends July 30, 2020 (60 days thereafter). Sue gave birth on February 4, 2020, and normally would have until March 5, 2020, to enroll her baby (or herself and her baby) in Medical Coverage. If Sue did not timely enroll in Medical Coverage, she may make an election do so within 5 days (30 days minus the 25 days following February 4 and before March 1) after the end of the Outbreak Period, or by August 4, 2020.

The Program generally provides that all election changes resulting from a HIPAA special enrollment event are effective as of the date of the event. Please be aware that if you do not make your election within the normal time period provided under the Program, but instead make an election pursuant to the extended time period under this provision, your election will only apply ***prospectively***, except in the case of special enrollment events related to births and adoptions. Special enrollment due to births and adoptions will be effective as of the date of the birth or adoption. In all other cases, the election will be effective as of the first pay period beginning after the election is received. You must complete an enrollment form and pay the required premiums in order to secure coverage.

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SECOND AMENDMENT AND SUMMARY OF CHANGES TO THE IVY TECH COMMUNITY COLLEGE FLEXIBLE BENEFIT PROGRAM AND SUMMARY

The Ivy Tech Community College Flexible Benefit Program and Summary ("Program") serves as both the Plan document and Summary of the Program. The Program was most recently amended and restated in its entirety, effective January 1, 2016, and was amended once thereafter.

Ivy Tech Community College of Indiana ("Ivy Tech") reserved the right to amend the Program pursuant to relevant provisions under the "Amendment and Termination" section of the Program. Pursuant to that section, the Program is now being amended as described below, generally effective as of January 1, 2021, unless otherwise stated.

This Second Amendment and Summary is now a part of the Program and should be included with your copy of the Program. If you need a copy of the Program, please contact Ivy Tech.

1. The introductory paragraph of **Section B. Maximum Reimbursement to Health Flexible Spending Account**, on page 17, is revised as follows:

> **B. Maximum Reimbursement to Health Flexible Spending Account.** There will be credited to your Health Flexible Spending Account, as of the beginning of the Program Year (or as of the later effective date of your election), the annualized amount which you have elected to have your salary reduced for the Program Year for the reimbursement of Qualifying Medical Expenses. For each Program Year, the maximum amount that you may elect to have credited to your Health Flexible Spending Account is the maximum amount permitted by the Internal Revenue Service with respect to that Program Year, or such lower limit communicated by Ivy Tech to all Eligible Employees at enrollment with respect to the Program Year, at its sole and absolute discretion. If you and your Spouse are both Participants, you may each elect to have the applicable maximum amounts credited to your Health Flexible Spending Account.

2. The introductory paragraph of **Section G. Carryover of Unused Health Flexible Spending Account Amounts**, on page 19, is revised as follows:

> **G. Carryover of Unused Health Flexible Spending Account Amounts.** If you have a balance remaining in your Health Flexible Spending Account at the end of the Program Year, an amount will be carried over to the immediately following Program Year equal to the lesser of: (1) $550 for the Program Year 2020, as increased thereafter at the sole discretion of Ivy Tech (but in no event greater than the applicable limit set by the Internal Revenue Service for the Program Year), or (2) the amount

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remaining in your Account after all of your Qualifying Medical Expenses submitted during the Program Year or within the related Run-Out Period have been reimbursed. This amount is called the "Available Carryover Amount." Any unused amounts in excess of the Available Carryover Amount will be forfeited. Your Available Carryover Amount, if any, will carry forward year to year.

3. The **COVID-19 ADDENDUM TO THE IVY TECH COMMUNITY COLLEGE FLEXIBLE BENEFIT PROGRAM AND SUMMARY**, located at the end of the Program, is revised in the same form as attached.

4. In all other respects, the Program shall remain unchanged.

This Second Amendment and Summary is executed as of the date and year written below.

IVY TECH COMMUNITY COLLEGE OF INDIANA

DocuSigned by:

By: Michael T. McNichols
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Print: Michael T. McNichols

Title: Vice President HR

Date: 12/21/2021

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COVID-19 ADDENDUM
TO THE
IVY TECH COMMUNITY COLLEGE
FLEXIBLE BENEFIT PROGRAM AND SUMMARY

Due to the national public health emergency related to COVID-19, the federal government has issued several temporary relief provisions that impact employee benefit plans. This Addendum outlines the terms of these relief provisions under the Program.

Ivy Tech established this COVID-19 Addendum effective January 1, 2020, to reflect relief granted for the 2020 Program Year. Ivy Tech is now revising this COVID-19 Addendum, to reflect additional relief granted for the 2021 Program Year.

MID-YEAR ELECTION CHANGES FOR FLEXIBLE SPENDING ACCOUNTS

A. Limited Opportunity for Election Changes During Program Year 2020 (Applies ***only*** to Health Flexible Spending Account and Dependent Care Flexible Spending Account Elections for 2020 Participants). Effective for the period beginning May 25, 2020 and ending October 23, 2020, if you had a Health Flexible Spending Account election in place and/or if you have a Dependent Care Flexible Spending Account election in place for the 2020 Program Year, you were permitted to make the following changes with respect to those election(s):

- You could make up to **two** separate elections to *increase*, *decrease*, or *stop* contributions to your Health Flexible Spending Account on a prospective basis.

- You could make up to **two** separate elections to *increase*, *decrease*, or *stop* contributions to your Dependent Care Flexible Spending Account on a prospective basis.

You were **not** permitted to seek a refund of Health Flexible Spending Account and/or Dependent Care Flexible Spending Account contributions that had already been made. In addition, a new annual election to decrease a Health Flexible Spending Account election could not be less than any amount to date that had been reimbursed from the Account (or, in other words, the decreased annual election amount was required to be at least equal to prior 2020 reimbursements).

EXAMPLE 1:

You made an annual election to contribute $2,400 to a Health Flexible Spending Account for the January 1, 2020 to December 31, 2020 Program Year. As of May 31, 2020, you have made $1,000 in contributions and you have received $1,500 in reimbursements for Qualifying Medical Expenses. You may choose to decrease your Health Flexible Spending Account contributions, effective June 1, 2020, to equal $500 for the remainder of the 2020 Program Year, so that your new annual election will be $1,500 [$1,000 for January to May plus $500 for June to December]. In this case, you will not be eligible to receive additional reimbursements for Qualifying Medical Expenses for the

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remainder of the Program Year because you have already received $1,500 in reimbursements.

EXAMPLE 2:

Assume the same facts as Example 1, except that you have only received $300 in reimbursements for Qualifying Medical Expenses as of May 31, 2020. You may choose to stop your Health Flexible Spending Account contributions, effective June 1, 2020, and you will remain eligible to receive $700 in reimbursements for the remainder of the Program Year [$1,000 in contributions less $300 in reimbursements].

An election change under this provision was required to be received by no later than October 23, 2020. The election was effective as soon as administratively feasible after receipt of your completed election (typically, the first pay check after you made your election).

B. Limited Opportunity for Election Changes During Program Year 2021 (Applies ***only*** to Health Flexible Spending Account and Dependent Care Flexible Spending Account Elections for 2021 Participants). Effective for the period beginning March 03, 2021 and ending October 26, 2021 if you had a Health Flexible Spending Account election in place and/or if you had a Dependent Care Flexible Spending Account election in place for the 2021 Program Year, you were permitted to make the following changes with respect to those election(s):

- You could make up to **two** separate elections to *increase*, *decrease*, or *stop* contributions to your Health Flexible Spending Account on a prospective basis.

- You could make up to **two** separate elections to *increase*, *decrease*, or *stop* contributions to your Dependent Care Flexible Spending Account on a prospective basis.

You were **not** permitted to seek a refund of Health Flexible Spending Account and/or Dependent Care Flexible Spending Account contributions that had already been made. In addition, a new annual election to decrease a Health Flexible Spending Account election could not be less than any amount to date that had been reimbursed from the Account (or, in other words, the decreased annual election amount was required to be at least equal to prior 2021 reimbursements). These rules applied the same way in Program Year 2021 as they applied in Program Year 2020 (see above examples for illustration).

An election change under this provision was required to be received by no later than October 26, 2021. The election was effective as soon as administratively feasible after receipt of your completed election (typically, the first pay check after you made your election).

CARRYOVERS AND INCREASED LIMITS FOR FLEXIBLE SPENDING ACCOUNTS

A. Additional Time to Spend Down Flexible Spending Accounts. Notwithstanding any provision of the Program to the contrary, if you had a Health Flexible Spending Account and/or a Dependent Care Flexible Spending Account in place for the 2020 Program Year, you were permitted to carryover the entire unused balance in such Accounts

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for reimbursement of Qualifying Medical Expenses or Dependent Care Expenses, as applicable, that were Incurred during the 2021 Program Year. In addition, for purposes of determining eligible Dependent Care Expenses, the definition of "Qualifying Individual" was read to substitute "under age 14" for "under age 13" solely with respect to providing reimbursements from the 2020 carryover amount that was available during the 2021 Program Year.

B. Increased Dependent Care Flexible Spending Account Limit for Program Year 2021. Notwithstanding any provision of the Program to the contrary, the maximum amount that you may have elected to have credited to your Dependent Care Flexible Spending Account for the 2021 Program Year was $10,500 (or $5,250 if you are married and do not file a joint federal income tax return for the year). The increased limit for the 2021 Program Year remains subject to the lower limit that applies if your Earned Income for the year – or if you are married, the actual or deemed Earned Income of your Spouse for the year – is less than $10,500.

EXTENSION OF SPECIAL ENROLLMENT PERIOD

Extension of Special Enrollment Period (Applies ***only*** to Medical Coverage Elections). If you and/or your Spouse or dependents experienced a special enrollment event on or after January 31, 2020 (January 1, 2020 if the event was related to Medicare or CHIP), and you have not enrolled yourself and/or your Spouse or dependents in Medical Coverage, you have additional time to enroll in Medical Coverage, even if the normal deadline has passed. Under the Program, you may submit your request for special enrollment within the following time periods:

- Within 31 days of the loss of other coverage or the addition of a new dependent due to marriage, birth, or adoption (or placement for adoption), or

- Within 60 days of the loss of eligibility for Medicare or CHIP, or eligibility for premium assistance under Medicare or CHIP.

In determining your deadline to enroll pursuant to this relief, you may disregard the period that ends on the earlier of (1) one year from the deadline that otherwise would have applied, or (2) 60 days after the end of the National Emergency related to Covid-19 (the "Outbreak Period"). In no case will a disregarded period exceed one year.

EXAMPLE:

Sue gave birth on June 14, 2020, and normally would have until July 15, 2020, to enroll her baby (or herself and her baby) in Medical Coverage. Under this relief, Sue's enrollment deadline is delayed until July 15, 2021, which is the earlier of one year from July 15, 2020 or the end of the Outbreak Period (which remained ongoing).

The Program generally provides that all election changes resulting from a HIPAA special enrollment event are effective as of the date of the event. Please be aware that if you do not make your election within the normal time period provided under the Program, but instead make an election pursuant to the extended time period under this provision, your

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election will only apply ***prospectively***, except in the case of special enrollment events related to births and adoptions. Special enrollment due to births and adoptions will be effective as of the date of the birth or adoption. In all other cases, the election will be effective as of the first pay period beginning after the election is received. You must complete an enrollment form and pay the required premiums in order to secure coverage.

THIRD AMENDMENT AND SUMMARY OF CHANGES
TO THE
IVY TECH COMMUNITY COLLEGE
FLEXIBLE BENEFIT PROGRAM AND SUMMARY

The Ivy Tech Community College Flexible Benefit Program and Summary ("Program") serves as both the Plan document and Summary of the Program. The Program was most recently amended and restated in its entirety, effective January 1, 2016, and was amended January 1, 2020 and January 1, 2021.

Ivy Tech Community College of Indiana ("Ivy Tech") reserved the right to amend the Program pursuant to relevant provisions under the **AMENDMENT AND TERMINATION** section of the Program. Pursuant to that section, the Program is now being amended as described below, generally effective as of January 1, 2026, to reflect the current operation of the Program since January 1, 2026 as a clarifying amendment.

This Third Amendment and Summary of Changes is now a part of the Program and should be included with your copy of the Program. If you need a copy of the Program, please contact Ivy Tech.

1. The third paragraph of **Section C. Health Savings Accounts**, on page 8, is revised as follows:

> The annual HSA Ivy Tech contributions will be made to the Health Savings Accounts of each HSA Eligible Employee, in the amount specified by Ivy Tech, in its sole discretion, and in accordance with the method and timing set forth in Exhibit A. Ivy Tech may modify the annual Ivy Tech contribution amounts and the timing thereof to HSA Eligible Employees, in its sole discretion, at any time.

2. **Section G. Carryover of Unused Health Flexible Spending Account Amounts**, on page 19, is revised as follows:

> **G. Carryover of Unused Health Flexible Spending Account Amounts.** If you have a balance remaining in your Health Flexible Spending Account at the end of the Program Year, an amount will be carried over to the immediately following Program Year equal to the lesser of: (1) $680 for the Program Year 2026, as increased thereafter at the sole discretion of Ivy Tech (but in no event greater than the applicable limit set by the Internal Revenue Service for the Program Year), or (2) the amount remaining in your Account after all of your Qualifying Medical Expenses submitted during the Program Year or within the related Run-Out Period have been reimbursed. This amount is called the "Available Carryover Amount." Any unused amounts in excess of the Available Carryover Amount will be forfeited. Your Available Carryover Amount, if any, will carry forward year to year.

3. The three examples in **Section G. <u>Carryover of Unused Health Flexible Spending Account Amounts</u>**, starting on page 19, are revised as follows:

• • •

EXAMPLE

You elect to have $2,500 contributed to your Health Flexible Spending Account for Program Year 2026 and Program Year 2027. On December 31, 2026, you have an unused Account balance of $800. On February 1, 2027, you submit claims of $350 for a Qualifying Medical Expense Incurred in 2026. On March 31, 2027 (the end of the 2026 Run-Out-Period), you have an Available Carryover Amount of $450 ($800 - $350). As a result, you have $2,950 for which you may submit claims for the remainder of 2027 ($450 carryover + $2,500 for the 2027 election). For the remainder of 2027, you submit claims in the amount of $2,700, leaving an unused balance of $250 on December 31, 2027. This amount may be carried forward to pay 2028 expenses, to the extent not depleted during the Run-Out Period.

EXAMPLE

Assume the same facts as above, except that you did not submit claims for Qualifying Medical Expenses Incurred in 2026 during the Run-Out Period. In that case, you would have an Available Carryover Amount of $680 for 2027, which is the lesser of $680 and the amount remaining at the end of the Run-Out Period ($800). The excess amount above $680 would be forfeited. You will then have $3,180 for which you may submit claims for the remainder of 2027 ($680 carryover + $2,500 for the 2027 election). For the remainder of 2027, you submit claims in the amount of $2,700, leaving an unused balance of $480 on December 31, 2027. This amount may be carried forward to pay 2028 expenses, to the extent not depleted during the Run-Out Period.

• • •

EXAMPLE

You are not enrolled in HDHP coverage in 2026, and you have an unused General Purpose Health Flexible Spending Account balance of $600 remaining on December 31, 2026. For 2027, you enroll in HDHP coverage and elect to contribute $2,500 to a Limited Purpose Health Flexible Spending Account. On January 15, 2027, you Incur a dental expense in the amount of $2,700

and submit the claim for reimbursement. You will be timely reimbursed $2,500 (your full 2027 election), and the remaining $200 will be reimbursed to the extent you have Available Carryover Amount. On February 15, 2027, you submit a medical expense Incurred in 2026 in the amount of $300. ***For purposes of reimbursement for 2026 expenses submitted during the Run-Out Period,*** "Qualifying Medical Expenses" are not limited by your current HDHP enrollment, and medical expenses can therefore be reimbursed. At the end of the Run-Out Period (March 31, 2027), you have $300 of Available Carryover Amount ($600 - $300). You will be reimbursed $200 for the excess January claim over the amount elected for 2027. You will then have $100 remaining for which you may submit claims Incurred in 2027. ***For purposes of reimbursement for 2027 expenses,*** "Qualifying Medical Expenses" are limited by your current HDHP enrollment to expenses permitted under a Limited Purpose Health Flexible Spending Account (*i.e.*, only dental and vision expenses are eligible for reimbursement).

4. **Section B. Reimbursement Amounts**, on page 21, is revised as follows:

B. Reimbursement Amounts. The maximum amount that you may elect to have credited to your Dependent Care Flexible Spending Account for any Program Year is the maximum amount permitted by the Internal Revenue Service with respect to that Program Year, or such lower limit communicated by Ivy Tech to all Eligible Employees at enrollment with respect to the Program Year, at its sole and absolute discretion. This maximum amount could be less if your Earned Income for the year - or if you are married, the actual or deemed Earned Income of your Spouse for the year - is less than the maximum amount permitted by the Internal Revenue Service.

5. **Exhibit A**, on page 42, is revised in the same form as attached.

6. In all other respects, the Program shall remain unchanged.

This Third Amendment and Summary of Changes is executed as of the date and year written below.

IVY TECH COMMUNITY COLLEGE OF INDIANA

By: _____

Printed Name: Marty Pollio

Title: President

Date: 4/13/2026

EXHIBIT A

IVY TECH HSA CONTRIBUTIONS

Effective as of January 1, 2026

Consumer Driven Health Plan 1 (CDHP1)

	Total Annual HSA Ivy Tech Contribution Amount	Initial Contribution (Prorated for coverage starting after January 1st)	26 Pay Contribution per Pay Period	20 Pay Contribution per Pay Period
Employee Only	$900	$450	$17.31	$22.50
Employee + Child(ren) Employee + Spouse Family	$1,800	$900	$34.62	$45.00

Consumer Driven Health Plan 2 (CDHP2)

	Total Annual HSA Ivy Tech Contribution Amount	Initial Contribution (Prorated for coverage starting after January 1st)	26 Pay Contribution per Pay Period	20 Pay Contribution per Pay Period
Employee Only	$600	$300	$11.54	$15.00
Employee + Child(ren) Employee + Spouse Family	$1,200	$600	$23.08	$30.00

Ivy Tech's HSA contributions shown in this Exhibit A will be made as follows:

- **50% Lump Sum:** Fifty percent (50%) of Ivy Tech's annual HSA Ivy Tech Contribution amount will be deposited in the first pay period of the Program Year for individuals who are HSA Eligible Employees as of the beginning of the Program Year. For Eligible Employees who first become HSA Eligible Employees after the beginning of the Program Year (including new hires or Eligible Employees who become benefits-eligible mid-year), this 50% lump-sum amount will be prorated based on the number of pay periods remaining in the Program Year and will be deposited as soon as administratively practicable.

- **50% Per-Pay-Period:** The remaining fifty percent (50%) of Ivy Tech's annual HSA Ivy Tech Contribution amount will be contributed in equal installments each remaining pay period. For Eligible Employees who first become HSA Eligible Employees after the beginning of the Program Year (including new hires or Eligible Employees who become benefits-eligible mid-year), these per-pay-period contributions will be prorated and will be made in equal installments beginning after their first pay period.

- **Termination of Employment:** If a HSA Eligible Employee terminates employment before the end of the Program Year, the Employee will not be required to repay any HSA Ivy Tech Contributions already made to the HSA Eligible Employee. Any remaining per-pay-period HSA Ivy Tech Contributions will stop, and the HSA Eligible Employee will receive only the contributions deposited prior to his or her termination of employment.

FOURTH AMENDMENT AND SUMMARY OF CHANGES
TO THE
IVY TECH COMMUNITY COLLEGE
FLEXIBLE BENEFIT PROGRAM AND SUMMARY

The Ivy Tech Community College Flexible Benefit Program and Summary ("Program") serves as both the Plan document and Summary of the Program. The Program was most recently amended and restated in its entirety, effective January 1, 2016, and subsequently amended effective January 1, 2020, January 1, 2021, and January 1, 2026.

Ivy Tech Community College of Indiana ("Ivy Tech") reserved the right to amend the Program pursuant to relevant provisions under the **AMENDMENT AND TERMINATION** section of the Program. Pursuant to that section, the Program is now being amended as described below, generally effective as of January 1, 2027.

This Fourth Amendment and Summary of Changes is now a part of the Program and should be included with your copy of the Program. If you need a copy of the Program, please contact Ivy Tech.

1. The definition of "**Accounts**" under the **DEFINITIONS** Article on page 1 is revised to update the definition of "Limited Purpose Health Flexible Spending Account" as follows:

> - "Limited Purpose Health Flexible Spending Account" means the accounting record maintained under the Program for each electing Participant who (i) is enrolled in a HDHP under the Medical Coverage, (ii) is eligible to participate in a Health Savings Account, and (iii) directs amounts to such Limited Purpose Health Flexible Spending Account for the reimbursement of Qualifying Medical Expenses described under **E. Qualifying Medical Expenses – Limited Purpose Health Flexible Spending Account**.

2. **Section C. Reinstatement of Participation by Former Participants**, on page 6, is revised as follows:

> **C. Reinstatement of Participation by Former Participants.** If you participate in the Program, terminate employment with Ivy Tech, and then return to employment with Ivy Tech within 30 days following your termination of employment within the same Program Year, you will be reinstated in your elections under the Program prior to the termination with no new waiting period, provided the Program eligibility and any applicable waiting periods have been met; however, your coverage will not be reinstated retroactively, and your compensation reductions will be prorated based upon the remaining pay periods in the Program Year. If you return to employment with Ivy Tech within 30 days following your termination of employment and your absence spans 2 Program Years, you must make a new election under the Program for the remainder of the Program Year but with no new waiting period, provided the Program eligibility and any applicable waiting period have been met. If you return to employment more than 30 days after such termination of employment, you must again satisfy the eligibility

requirements and any applicable waiting period and make a new election under the Program for the remainder of the Program Year.

3. The subsection titled **Enrollment in a Qualified Health Plan** under **Section E. Changes in Election During the Program Year**, on page 15, is revised as follows:

Enrollment in a Qualified Health Plan (Applies ***only*** to Medical Coverage Elections). You may make an election to revoke Medical Coverage for you, your Spouse or dependent, on a prospective basis, that relates to your (or your Spouse's or dependent's) enrollment in a "Qualified Health Plan" through a health insurance marketplace (a "Marketplace"). The following criteria must be met:

- you are eligible to enroll in a Qualified Health Plan through a Marketplace during either a special enrollment period for such coverage or during the Marketplace's annual open enrollment period; and

- you have enrolled, or intend to enroll, yourself (and your Spouse and dependents, if applicable) in a Qualified Health Plan through a Marketplace for new coverage that is effective no later than the day immediately following the last day that Medical Coverage is revoked.

In addition, you may make an election to revoke family Medical Coverage on a prospective basis, if that revocation relates to your (or your Spouse's or dependent's) enrollment in a Qualified Health Plan through a Marketplace. The following criteria must be met:

- your Spouse and/or your dependent are eligible to enroll in a Qualified Health Plan through a Marketplace during either a special enrollment period for such coverage or during the Marketplace's annual open enrollment period; and

- your Spouse and/or your dependent have enrolled, or intend to enroll, themselves in a Qualified Health Plan through a Marketplace for new coverage that is effective no later than the day immediately following the last day that family Medical Coverage is revoked. If you do not enroll in a Qualified Health Plan through a Marketplace, you must elect employee-only Medical Coverage (or family Medical Coverage including one or more of your dependents who are already covered).

A "Qualified Health Plan" means a fully-insured health plan that has been certified by the applicable authorities to meet the criteria for certification in a Marketplace and is offered by a health insurance issuer that is appropriately licensed to offer such coverage and meets certain other requirements under federal law. Ivy Tech may require you to certify that you have enrolled, or intend to enroll, yourself, and your Spouse and dependents, if applicable, in the Qualified Health Plan.

4. **Section E. Qualifying Medical Expenses – Limited Purpose Health Flexible Spending Account**, on page 18, is revised as follows:

> **E. Qualifying Medical Expenses – Limited Purpose Health Flexible Spending Account.** If you are enrolled in a High Deductible Health Plan, reimbursement from your Limited Purpose Health Flexible Spending Account is limited to dental and vision expenses until you satisfy the applicable minimum annual deductible required under Code Section 223 based on your High Deductible Health Plan coverage level (self-only or family coverage). No other Qualifying Medical Expenses described in Section D. (other than dental and vision expenses) above will be reimbursed before you satisfy such minimum annual deductible.
>
> After you satisfy the applicable minimum annual deductible required under Code Section 223 based on your High Deductible Health Plan coverage level (self-only or family coverage), your Limited Purpose Health Flexible Spending Account may reimburse all Qualifying Medical Expenses described in Section D. above, subject to the terms of the Program and any substantiation requirements established by Ivy Tech.

5. **Section F. Ceasing to be a Participant with Respect to the Health Flexible Spending Account**, starting on page 18, is revised to add the following sentence to the end thereof:

> COBRA will only be offered to qualified beneficiaries who have underspent accounts (see **Qualified Beneficiaries** on page 32). A qualified beneficiary has an underspent account if, as of the date of the qualifying event, the maximum benefit available for the remainder of the Program Year (including your annual election and any applicable carryover amount minus what you have already been reimbursed) is more than the maximum COBRA premium that you will be charged for the rest of the Program Year. If a qualified beneficiary does not have an underspent account, COBRA continuation coverage under the Health Flexible Spending Account will not be offered.

6. The third paragraph of **Section G. Carryover Unused Health Flexible Spending Account Amounts**, immediately following the first two examples on page 19, is revised as follows:

> The Available Carryover Amount will be available to you after the Run Out Period for the prior Program Year to reimburse Qualifying Medical Expenses Incurred in the current Program Year in the same way that your prior year's election could be used, except that if you are currently enrolled in HDHP coverage, your Available Carryover Amount will automatically convert to and be administered only as a Limited Purpose Health Flexible Spending Account, subject to the terms and conditions applicable to the Limited Purpose Health Flexible Spending Account, even if you were enrolled in a General Purpose Health Flexible Spending Account during the prior year. This limitation does not apply, however, if you use your Account balance during the Run-Out Period for reimbursement of claims Incurred

in the prior Program Year during which you were enrolled in a General Purpose Health Flexible Spending Account and non-HDHP coverage.

7. The third example on page 20 of **Section G. Carryover Unused Health Flexible Spending Account Amounts** is revised as follows:

• • •

EXAMPLE

You are not enrolled in HDHP coverage in 2026, and you have an unused General Purpose Health Flexible Spending Account balance of $800 remaining on December 31, 2026. For 2027, you enroll in HDHP coverage and elect to contribute $2,500 to a Limited Purpose Health Flexible Spending Account. On January 15, 2027, you Incur a dental expense in the amount of $2,700 and submit the claim for reimbursement. You will be reimbursed $2,500 (your full 2027 election), and the remaining $200 will be reimbursed to you from the first $680 of your unused 2026 Account balance that is eligible to become an potential Available Carryover Amount from 2026. On February 15, 2027, you submit a medical expense Incurred in 2026 in the amount of $300. ***For purposes of reimbursement for 2026 expenses submitted during the Run-Out Period,*** "Qualifying Medical Expenses" are not limited by your current HDHP enrollment, and medical expenses can therefore be reimbursed. At the end of the Run-Out Period (March 31, 2027), you have $180 of Available Carryover Amount ($680 maximum carryover - $200 January dental claim - $300 February medical expense = $180). You will then have $180 remaining for which you may submit claims Incurred in 2027. The remaining $120 left of your $800 balance remaining at the end of 2026 is forfeited. ***For purposes of reimbursement for 2027 expenses,*** "Qualifying Medical Expenses" are limited by your current HDHP enrollment to expenses permitted under a Limited Purpose Health Flexible Spending Account. Accordingly, prior to your satisfaction of the applicable minimum annual deductible required for High Deductible Health Plans, only dental and vision expenses are eligible for reimbursement. After you satisfy such minimum annual deductible, other Qualifying Medical Expenses may also be eligible for reimbursement in accordance with the Program.

8. The following paragraph is added to the end of **Section C. Claims Provisions Applicable to Both Health Flexible Spending Account and Dependent Care Flexible Spending Account**, on page 30, as a new subsection (7), to read as follows:

(7) **Statute of Limitations.** For all claims, you have the right to bring a civil action under ERISA Section 502(a) following a denial on appeal. Any such legal action to request coverage or recover benefits under the Program following a denial must begin within one (1) year after completion of the Program's claims process.

9. **Section A. Qualified Beneficiaries**, on page 32, is revised to add at the end thereof:

> COBRA continuation coverage under the Health Flexible Spending Account will only be offered to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if, as of the date of the qualifying event, the maximum benefit available for the remainder of the Program Year (including your annual election and any applicable carryover amount minus what you have already been reimbursed) is more than the maximum COBRA premium that you will be charged for the rest of the Program Year. If a qualified beneficiary does not have an underspent account, COBRA continuation coverage under the Health Flexible Spending Account will not be offered.

10. The **COVID-19 ADDENDUM TO THE IVY TECH COMMUNITY COLLEGE FLEXIBLE BENEFIT PROGRAM AND SUMMARY**, located at the end of the Program, is deleted in its entirety.

11. In all other respects, the Program shall remain unchanged.

This Fourth Amendment and Summary of Changes is executed as of the date and year written below.

IVY TECH COMMUNITY COLLEGE OF INDIANA

By: _____

Printed Name: Sue Ellspermann

Title: President

Date: 10/13/20