CENTREVILLE LAYTON SCHOOL
HEALTH AND DENTAL PLAN SUMMARY PLAN DESCRIPTION (SPD)

1. INTRODUCTION

Centreville Layton School (the Company) maintains this group health, dental, and vision plan (the Plan) to provide benefits to you and your eligible dependents. Your benefits are provided under an insurance contract between the Company and CIGNA (the Insurer).

This document and the attached certificate of insurance booklet from the Insurer make up your summary plan description (SPD). Please read this document and the attached booklet to learn about your health plan benefits. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information. Please keep your health plan documents in a safe place for future reference.

Please note that this document does not provide any substantive rights to benefits that are not included in the attached certificate of insurance booklet.

If you have any questions regarding the Plan, including whether you are eligible to participate in the Plan, please contact the Company. If you have questions regarding benefits payable under the Plan, please contact the Insurer.

2. PLAN INFORMATION

Name of Plan:

Cigna HSA Plan
Cigna Dental PPO Plan
VSP Vison Plan

Type of Plan:

Group Health Plan
Group Dental Plan
Group Vision Plan

Policy Number:

Health Plan = 00611430
Dental Plan = 00611430
Vision Plan = GUVC-AQ3W

Plan Sponsor:

Centreville Layton School

Plan Administrator:

Centreville Layton School

Agent for Service of Legal Process on the Plan:

Centreville Layton School
6201 Kennett Pike
Centreville, DE 19807

Legal process can be served on the plan administrator.

Insurance Company:

Health and Dental Insurance
CIGNA
Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192

Vision Insurance
VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Identification Numbers:

1. Plan Sponsor's Employer Identification Number (EIN): 51-0232858
2. Health Plan Number: 00611430
3. Dental Plan Number: 00611430
4. Vision Plan Number: GUVC-AQ3W

Plan Year:

Health Plan: July 1st through June 30th
Dental Plan: July 1st through June 30th
Vision Plan: July 1st through June 30th

Effective Date:

The effective date of the Plan is 7/1/2025.

IMPORTANT DISCLAIMERS

Conflicting Terms

If the terms of this document conflict with the terms of the insurance contract between the Company and the Insurer, the insurance contract will control. This document may not confer additional rights that are not contained in the insurance contract.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Company or any other arrangement indicating that you will be employed for any specific period of time.

3. FUNDING AND ADMINISTRATION

Funding

The Plan is fully insured. Plan benefits are payable pursuant to a contract with the Insurer. Claims for benefits are sent to the Insurer and the Insurer is responsible for paying benefits. The Company is not responsible for paying benefits under the Plan.

Premium contributions are paid in part by the Company out of its general assets and in part by employees through pre-tax contributions. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contract entered into between the Company and the Insurer will be allocated, if consistent with the fiduciary obligations imposed by ERISA and permitted by law, to reimburse the Company for premiums that it has paid.

Type of Administration

Because the Plan's benefits are provided through an insurance contract, both the Insurer and the Company administer the Plan.

The Company, as plan administrator, has the discretionary authority to interpret and administer the Plan. This includes making determinations of an individual's eligibility to participate in the Plan. The Insurer has the authority to make benefit determinations under the Plan and is the Named Fiduciary responsible for following the Plan's claims procedures.

Compliance with State and Federal Laws

To the extent required by law, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, as amended, including the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998 (WHCRA), the Family and Medical Leave Act of 1993 (FMLA), the Mental Health Parity Act (MHPA), the Mental Health Parity and Addiction Equity Act

(MHPAEA), the Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Affordable Care Act (PPACA).

Amendment or Termination

The Company may modify, amend or terminate the Plan at any time at its sole discretion. The right to modify, amend or terminate also applies to the insurance contract between the Company and the Insurer. Any modification, amendment, or termination will be communicated to participants under the Plan.

4. ELIGIBILITY AND PARTICIPATION

Eligibility and Enrollment

To be eligible to participate in the Plan, you must meet certain requirements. Full-Time Staff Employees and Full-Time Faculty Employees as defined in the company's employee handbook are eligible to participate in the Plan.

3. Full-Time Staff Employees classified as working 30 or more hours per week for the contract year.
4. Full-Time Faculty Employees classified as working 30 or more hours per week during the academic year.

Full-Time Employees are those who are not in a temporary status and who are regularly scheduled to work The Company's full-time schedule. They are eligible for The Company's benefit package, subject to the terms, conditions, and limitations of each benefit program. Full-Time status will be defined on the employee contract.

Spousal and dependents coverage is available to those employee's enrolled in the plan.

Employees must pay the below percentages of the employee premium for coverage on each of the plans:

Group Health Plan = 10%
Group Dental Plan = 20%
Group Vision Plan = 75%

The Company will pay the below percentages of the employee premium for coverage on each of the plans:

Group Health Plan = 90%
Group Dental Plan = 80%
Group Vision Plan = 25%

You must pay 100% of the premium for coverage of any dependents or spouse on all Group Plans.

For the Health Plan, the Company does not contribute to the HSA bank account.

The waiting period for new employees or current employees who have become eligible is 30 days. After 30 days, the employee will be eligible to be enrolled in the Plan on the next first of the month.

Coverage will be extended to your non-custodial child if required by a Qualified Medical Child Support Order (QMCSO). Please contact Melanie Payne at the Company for more information on the Plan's procedures for determining whether a medical child support order qualifies as a QMSCO.

Your coverage terminates on the last day of the month in which you terminate employment with the Company. Coverage may also terminate in other circumstances, such as failure to pay required premiums, failing to meet eligibility requirements, submitting fraudulent claims and other reasons described in the attached certificate of coverage booklet. Coverage for your spouse and dependents terminates when your coverage ends and for other reasons described in the attached certificate of coverage booklet, such as divorce or reaching the Plan's limiting age for dependents.

Special Enrollment Rights

In certain special circumstances, you and/or your dependents may enroll in the Plan at times other than open enrollment. The attached certificate of insurance booklet and the Plan's Special Enrollment Notice contain more information about potential special enrollment rights.

Continuation of Coverage

If your coverage or the coverage of your spouse or dependents terminates because of certain reasons known as qualifying events (such as termination of employment, reduction in hours, divorce, death, or child ceasing to be a dependent under the plan), you, your spouse and your dependents may be entitled to continue health care coverage for a certain period of time under a federal law called COBRA. In addition, if you are absent from employment due to military service, you may be entitled to continuation of coverage or reinstatement in the Plan under a federal law called USERRA. You or your dependents may have to pay for such coverage. Contact Melanie Payne at the Company for more information about your rights under COBRA and/or USERRA.

5. PLAN BENEFITS

The Plan provides benefits to you and your eligible spouse and dependents while you are eligible for and covered by the Plan.

Cigna Commitment to Quality
Our **Commitment to Quality** guide gives you access to the latest information about our program activities and results, including how we met our goals, as well as details about key guidelines and procedures. Log on to the website shown on your ID card to access this information. If you have questions about the quality program, would like to provide your feedback and/or cannot access the information online and would like a paper copy, please call the phone number on your ID card.

Women's Health and Cancer Rights Act
This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

• all stages of reconstruction of the breast on which the mastectomy was performed;

• surgery and reconstruction of the other breast to produce a symmetrical appearance; and

• prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act
Under the federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

About This Plan

The Company has established an Employee Welfare Benefit Plan within the meaning of the Employee

Retirement Income Security Act of 1974 (ERISA). As of August 1, 2014, the medical benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical benefit terms described in this booklet. The Plan may be amended from time to time.

This booklet takes the place of any other issued to you on a prior date.

The medical benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna Health and Life Insurance Company (Cigna) processes claims and provides other services to the Employer related to the self-funded benefits. Cigna does not insure or guarantee the self-funded benefits.

Discretionary Authority
The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded medical benefit Plan. The Plan Administrator in his or her discretionary authority,

will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and claims for benefits.

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Cigna Health and Life Insurance Company as the appeals fiduciary. Cigna will have the discretionary authority to determine whether a claim should be paid or denied on appeal and according to the Plan provisions.

Plan Modification/Termination
The Employer may:

• change the contributions a Member must pay for benefits; or

• amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

Rescission
A Member's health coverage may not be rescinded (retroactively terminated) by Cigna, the Employer or Plan sponsor unless:

• the Employer or Plan sponsor or a Member (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or

• the Employer or Plan sponsor or a Member (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Selection of a Primary Care Provider
This Plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of network primary care providers, visit the website or contact Member Services at the phone number listed on your ID card. A pediatrician may be designated as a child's primary care provider.

For a detailed description of benefits available under the Plan, please review the attached certificate of insurance booklet. It is your responsibility to understand your benefits under the Plan and ask questions if you need more information.

Benefits are no longer payable if your coverage is terminated for any reason. The Plan reserves the right to recover overpayments of benefits or benefits paid in error through the rights of subrogation and reimbursement as described more fully in the attached certificate of insurance booklet.

Please review the attached certificate of insurance booklet carefully for information on other situations that may affect your right to receive benefits under the Plan, such as applicable deadlines for submitting claims.

6. CLAIMS PROCEDURES

Benefit Claims and Appeals

The Insurer is responsible for reviewing and deciding all benefit claims in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. The attached certificate of insurance booklet provides more information about the Insurer's claims procedures, including information on how to file a claim.

Claim Appeals

The Insurer may deny claims in part or in full pursuant to the terms of the Plan. If your claim is denied, you will be notified of the denial. You may appeal any denial of a claim. The Insurer will review your denied claim and will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law.

If you do not appeal a denial by the applicable deadlines, you will lose certain rights, such as the right to file a lawsuit regarding the denial and you will not be deemed to have exhausted your internal administrative rights.

In some cases, you may have the right to an external review, which consists of review by an independent third party. The attached certificate of insurance booklet provides more information about external review.

7. STATEMENT OF ERISA RIGHTS

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if the plan administrator is required by law to file a Form 5500. The plan administrator may be required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.