THE SECOND RESTATED
MECOSTA-OSCEOLA INTERMEDIATE SCHOOL DISTRICT
CAFETERIA PLAN

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The Mecosta-Osceola Intermediate School District Cafeteria Plan was established effective on March 1, 1993. It was amended as of March 1, 1996 and amended and restated as of September 1, 2003. With this instrument, the Mecosta-Osceola Intermediate School District is amending and restating the cafeteria plan, for the exclusive benefit of its Employees, which shall henceforth be known as the "The Second Restated Mecosta-Osceola Intermediate School District Cafeteria Plan," and for convenience shall be referred to in this document as the "Plan."

1.0 PURPOSE.

1.1 Intent of the Plan. The Plan is intended to meet the requirements of a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code") and is to be interpreted in a manner consistent with the requirements of applicable law. This Plan and the Benefit Plans ancillary hereto are to be treated as a single Plan.

1.2 Purpose of the Plan. The primary purpose of the Plan is to attract and retain qualified personnel.

1.3 Plan not an Employment Agreement. This Plan is not an employment agreement between any Participant and the Employer, nor does this Plan give any Participant any right to be retained as an employee of the Employer.

1.4 Rights of Employees. The rights of Employees under the Plan are hereby acknowledged to be legally enforceable. Except as may be permitted under applicable law, the Plan is maintained for the exclusive benefit of Employees of the Employer who are eligible to be participants in the Plan. The Plan has been established with the intention of being maintained for an indefinite period of time.

2.0 DEFINITIONS.

The following definitions apply to this Plan and all documents and instruments related to this Plan:

2.1 Administrator -- The Employer, a committee created by the Board of the Employer, or such other person or entity as may be engaged from time to time by the Employer to supervise the administration of the Plan.

2.2 Benefit Plan -- A separate benefit plan maintained by the Employer for the purpose of providing Benefits under this Plan.

2.3 Benefit Schedule -- The Exhibit that is attached to this Plan as Exhibit A, which describes the benefits available to Participants under the Plan. The Benefit Schedule may be

changed by the Employer from time to time, without notice, to the extent that the Employer deems it reasonably necessary for the sound and economical administration of the Plan; provided that the Employer's discretion to change the Benefit Schedule may not be exercised in a manner that is inconsistent with the provisions of any applicable Collective Bargaining Agreement as to those Employees who are within the bargaining unit covered by the Collective Bargaining Agreement. A change to the Benefit Schedule will be treated as an amendment to the Plan.

2.4 Board -- The duly constituted Board of Education of the Employer, according to the laws of the State of Michigan and the Employer's governing instruments.

2.5 Claimant -- A person submitting a claim for Benefits under this Plan, or a Policy or Benefit Plan maintained to provide Benefits in conjunction with the Plan. A Claimant can be a Participant, a Beneficiary of a Participant (where appropriate), or a legal representative of a Participant or Beneficiary who would otherwise be the Claimant, but for a condition making the Participant or Beneficiary incapable of personally submitting the claim.

2.6 Code -- The Internal Revenue Code of 1986, as amended.

2.7 COBRA -- The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.8 Collective Bargaining Agreement -- A Collective Bargaining Agreement between the Employer and Employees who are members of a bargaining unit.

2.9 Dependent -- Any person who fits within the definition of a dependent under a Policy or Benefit Plan that is maintained by the Employer to provide Benefits under this Plan.

2.10 Effective Date -- The Effective Date of this Plan, being July 1, 2020.

2.11 Election Period -- The Election Period will be the period preceding the first day of each Plan Year designated by the Administrator. As the Plan covers groups of Eligible Employees whose benefits are to be administered with different Plan Years, the Administrator will designate Election Periods that coincide with the Plan Years described in Section 2.21. The Election Period is the time during which Participants in the Plan may select the types of benefits and the allocation of funds to each benefit for the next period of coverage, all in the manner that is permitted by this Plan. Notwithstanding the foregoing, any Employee who becomes eligible to participate in the Plan on a date that is not within the Election Period will be permitted to make the selections and allocations during the thirty (30) calendar day period immediately preceding the date the Employee's participation under the Plan is to begin. The Administrator may on a uniform basis provide newly hired Employees a window of up to thirty (30) days after their hire dates to make their elections and elections made during this period can be effective as of the Employee's hire date (i.e., on a retroactive basis); provided that the salary reductions to pay for elected benefits must come from Compensation that is not yet available when the election is made.

2.12 Eligible Employee -- An Employee who meets the requirements for eligibility to participate under this Plan under Section 3.1 of this Plan.

2.13 **Employee** -- Any individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a Collective Bargaining Agreement, unless provided under the Collective Bargaining Agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

2.14 **Employer** -- The Mecosta-Osceola Intermediate School District.

2.15 **ERISA** -- The Employee Retirement Income Security Act of 1974, as amended.

2.16 **Fiduciary** -- This Plan is a governmental plan and, therefore, is not subject to ERISA as of the Effective Date. If, however, this Plan becomes subject to ERISA, the Employer, the Administrator, and any other person involved in the administration of the Plan, as described in Section 3(21) of ERISA, shall be considered a Plan Fiduciary.

2.17 **Insurer** -- Any licensed insurance company issuing a Policy through which benefits under this Plan are provided.

2.18 **Medical Insurance Premium Account** -- An account established and maintained for each Participant who elects a reduction in Salary to pay Premiums for coverage under a Policy maintained by the Employer to provide health care to Employees.

2.19 **Participant** -- An Employee who participates in this Plan under Section 3.0.

2.20 **Plan** -- This cafeteria plan, established by the Employer under Section 125 of the Code.

2.21 **Plan Year** -- The Plan Year is the period of coverage for Benefits under the Plan. As to all Eligible Employees other than Employees who are members of the Michigan Education Association bargaining unit, the Plan Year is the 12 month period beginning July 1 and ending the next succeeding June 30. As to Eligible Employees who are members of the Michigan Education Association bargaining unit, the Plan Year is the calendar year.

2.22 **Policy** -- A contract with an Insurer maintained by the Employer for the purpose of providing benefits under this Plan. All such Policies are incorporated into this Plan by reference.

2.23 **Premium** -- The amount contractually required to maintain coverage under a Policy.

2.24 **Salary** -- The wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Salary" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

3.0 ELIGIBILITY, BENEFIT AND PARTICIPATION

3.1 **Eligibility**. An Eligible Employee who is not covered under a Collective Bargaining Agreement may participate under the Plan if the Employee satisfies the eligibility requirements to receive coverage under the Policy or Policies maintained by the Employer for purposes of its health insurance plan.

An Employee who is covered under a Collective Bargaining Agreement is eligible to participate under the Plan if such participation is mandated under the Collective Bargaining Agreement and the Employee has satisfied all additional conditions for participation as are stated in the Collective Bargaining Agreement, if any.

3.2 **Participation**. An Employee who meets the eligibility requirements set forth in Section 3.1 will participate from the Effective Date of the Plan, provided the Employee has filed a benefit election form with the Administrator under this Plan**.** Any Employee who fails to properly submit a benefit election form as specified by the Administrator during an Election Period shall be considered to have elected not to participate for the ensuing Plan Year. Any other Employee will become a Participant on the first day of the month coinciding with or next following the date the Employee becomes eligible as set forth in Section 3.1, provided the Employee has filed a benefit election form with the Administrator under this Plan.

All Employees who are participants in the Plan as of the Effective Date of this restatement shall continue their participation for the remainder of the Plan Year, in accordance with their elections for that Plan Year.

If an Employee does not file a benefit election form at the time of the Employee's initial eligibility, the Employee may begin participating as of the first day of any following Plan Year, provided the Employee is eligible to participate at that time and the Employee files a benefit election form with the Administrator in accordance with this Plan during the relevant Election Period.

4.0 CONTRIBUTIONS AND FUNDING

4.1 Employer Contributions. The amount of the Employer's contributions under this Plan for a Plan Year will be determined during the Election Period, based on the annual benefit election forms completed by Participants under this Plan. The Employer will pay the cost of coverage on behalf of Participants under any Policies as provided under applicable Collective Bargaining Agreements, other agreements or applicable law, and Participants shall pay the amounts in excess of the contributions of the Employer through the reduction of Participants' Salaries, as described in the following paragraph, on forms and under the procedures established by the Administrator and under the relevant Collective Bargaining Agreement (the pertinent provisions of which are incorporated in this Plan by reference). Amounts will be credited to the bookkeeping accounts of Participants. The Employer will not be required in any way to fund the accounts, set aside, earmark or entrust any fund, policy or money with which to pay its obligations under the Plan. All benefits, except those provided under a Policy, will be paid from the Employer's general assets.

The Employer will use reasonable methods for determining the total cost of coverage under Policies, and the Employer's determination will be binding on all interested persons.

4.2 Salary Reduction Contributions. As necessary to fund the Benefits elected under the Plan that are not subject to Automatic Enrollment, each Participant will enter into a written Salary Reduction Agreement with the Employer in accordance with procedures established by the Administrator, by which the Participant will agree to a reduction in the Participant's Salary for the Plan Year, all as specified in the Salary Reduction Agreement. Each Salary Reduction Agreement will be subject to the following terms and conditions:

A. The total amount of the reduction in Salary will be equal to that portion of the Benefit costs to be funded by the Participant.

B. Except as otherwise permitted in this Plan, the reduction of Salary will apply in all payroll periods within the applicable Plan Year, and to all of the Participant's periodic payroll checks during the Plan Year.

C. A Participant may not amend or revoke the Participant's election on or after the first day of the Plan Year for which the election is intended to be effective; except that a Participant may prospectively amend or revoke an election on or after the first day of the relevant Plan Year, for the remainder of the Plan Year, if the amendment or revocation is a "permitted election change" as more fully described in Section 4.3 of this Plan. If this Plan includes a Health Savings Account (HSA) Contribution Benefit, then a Participant may amend or revoke the Participant's election relative to that Benefit as provided in the description of the Health Savings Account (HSA) Contribution Benefit contained in the attached Benefit Schedule (Exhibit A).

D. The amount of the reduction in Salary specified in a Participant's Salary Reduction Agreement may be changed by the Administrator, in its sole discretion, for the purpose of complying with applicable rules against discrimination, as more fully described in Section 4.4,

or as permitted under Section 4.3.E.2.a. In addition, the Administrator may make reasonable adjustments in reductions of Salary to accommodate elections by Participations with respect to pay schedules offered Employees by the Employer.

E. If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary reduction amounts from any remaining Salary.

F. If the Employer receives any rebates attributable to medical insurance options offered by the Employer, such rebates shall be used to (i) reduce Premiums for all medical insurance plan options for Participants covered when the rebate is received, (ii) to reduce Premiums for current Participants covered by the option receiving the rebate, (iii) or as a cash refund to current Participants covered by the option receiving the rebate. In each case, the rebate shall be allocated in proportion to actual contributions to premiums. Rebates that are distributed as a reduction of Premium cost or in cash to Participants will be subject to federal income and employment taxes in the year of distribution.

4.3 Permitted Election Changes. For purposes of Section 4.2.C of this Plan, a Participant may revoke an election under this Plan during the Plan Year for which the election was intended to be made, and prospectively make a new election for the remainder of the Plan Year, under the following circumstances:

A. HIPAA Special Enrollment Rights. A Participant may change an election under the Plan if the Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), permitting the Participant to revoke a prior election for group health plan coverage and to make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change under this Plan corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

1. A Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (i) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (ii) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

2. A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

3. The Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

4. The Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program (SCHIP) with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this sub-section, the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

B. Change in Status. A participant may revoke an election for accident and health coverage or group-term life insurance coverage and make a new election for the remaining portion of the Plan Year if under the circumstances (i) a change in status occurs; and (ii) the election change satisfies the "consistency requirement" in subparagraph 2 of this paragraph B.

1. Change in status events. The following events are changes in status for purposes of this paragraph B:

a. Events that change an employee's legal marital status, including marriage, death of a spouse, divorce, legal separation, or annulment.

b. Events that change the number of the Participant's dependents, including by reason of birth, adoption, placement for adoption, or death of a dependent (as defined in Section 152 of the Code).

c. Events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; and, in addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer or of the employer of the Participant's spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subparagraph c.

d. Events that cause a Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the Employer's accident or health plan.

e. A change in the place of residence of the Participant, spouse, or dependent.

2. Consistency Rule

a. Application to accident or health coverage and group-term life insurance. An election change satisfies the requirements of this subsection B with respect to accident or health coverage or group-term life insurance only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under specific Benefit. A change in status that affects eligibility under a Benefit includes a change in status that results in an increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the Benefit. The consistency rule shall be applied in a manner consistent with Treasury Regulation Section 1.125-4.

b. Application to other Qualified Benefits. An election change satisfies the requirements of this subsection B with respect to other qualified benefits (i.e., other than accident and health coverage or group-term life insurance) if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under the specific Benefit. In addition, an election change that is on account of and corresponds with a change in status that effects expenses under a dependent care assistance benefit or adoption assistance benefit (if such benefits are provided under this Plan) satisfies this subsection B.

c. Exception for COBRA. If a Participant, or spouse or dependent of a Participant becomes eligible for continuation coverage under a group health plan of the Employer as provided in Section 4980B of the Code or any similar state law, the Plan shall permit an election to increase payments under the Plan in order to pay for the continuation coverage.

C. Judgment, Decree, or Order. Notwithstanding anything contained herein to the contrary, in the case of a Participant who becomes subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for the Participant's child or for a foster child that is the Participant's dependent, the Plan shall:

1. Change the Participant's election under the Plan if doing so is necessary in order for such coverage to be provided for the child under the plan of the Employer through which accident or health coverage is provided to the Participant; or

2. Permit the Participant to make an election change to cancel coverage for the child if:

a. The order requires that coverage be provided by the Participant's spouse, former spouse, or other individual; and

b. That coverage is, in fact, provided.

D. Entitlement to Medicare or Medicaid. A Participant may make a prospective election change to cancel Benefits under this Plan, if any, relating to the coverage of the Participant, the Participant's spouse or a dependent under the accident or health coverage maintained by the Employer when the Participant, the Participant's spouse or dependent becomes eligible for coverage under Medicare or Medicaid. In addition, a Participant may make a prospective election to commence or increase coverage under the accident or health coverage maintained by the Employer when the Participant, the Participant's spouse or dependent who has been entitled to such coverage under Medicare or Medicaid losses eligibility for such coverage.

E. Significant Changes in Cost or Coverage.

1. General. A participant may prospectively amend or revoke an election under this Plan on or after the first day of the relevant Plan Year, for the remainder of the Plan Year, for changes in cost or coverage as described and permitted in this subsection E; provided, however, that this subsection does not apply to an election change with respect to a health flexible spending account (or on account of a change in cost or coverage under a health flexible spending account) where such a Benefit is provided under this Plan.

2. Cost Changes.

a. Automatic changes. If the cost of a qualified Benefit, to which Participants contribute through elective contributions, increases (or decreases) during a period of coverage, the Plan Administrator shall, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the affected Participants' elective contributions for that Benefit.

b. Significant Cost Changes. Notwithstanding paragraph 2.a. (regarding automatic changes), if the cost charged to a Participant for a Benefit Package Option significantly increases or significantly decreases during a Plan Year, the Administrator may offer the Participant an opportunity to make a corresponding change in his or her Benefit election under the Plan. Changes that may be made include commencing participation in the Plan for the Benefit Package Option with a decrease in cost or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another Benefit Package Option providing similar coverage or dropping coverage if no other Benefit Package Option providing similar coverage is available. For purposes of this Plan, the term "Benefit Package Option" means a qualified Benefit under Section 125(f) of the Code that is offer under the Plan, or an option for coverage under an underlying accident or health plan.

c. Application of Cost Changes. For purposes of paragraphs a and b of this subsection E, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from

an action taken by the Participant (such as switching between full- time and part-time status) or from an action taken by an Employer (such as reducing the amount of employer contributions for a class of employees).

d. Application to Dependent Care. This subsection E concerning cost changes applies in the case of a Dependent Care Assistance plan, if such a Benefit is provided under the Plan, only if the cost change is imposed by a dependent care provider who is not a relative of the employee, as described in Section 152(a)(1) through (8) of the Code, incorporating the rules of Section 152(b)(1) and (2) of the Code.

3. Coverage Changes.

a. Significant Curtailment Without Loss of Coverage. If a Participant (or a Participant's spouse or dependent) has a significant curtailment of coverage under a Benefit during a period of coverage that is not a loss of coverage (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit under an accident or health plan), the Plan shall permit the Participant to revoke his or her election for that coverage and, in lieu thereof, to elect to receive on a prospective basis coverage under another Benefit Package Option providing similar coverage. For purposes of this Plan, "similar coverage", means coverage for the same category of Benefits for the same individuals. Coverage under a Benefit is significantly curtailed only if there is an overall reduction in coverage provided under the Benefit so as to constitute reduced coverage generally.

b. Significant Curtailment With Loss of Coverage. If a Participant (or the Participant's spouse or dependent) has a significant curtailment that is a loss of coverage, the Plan shall permit that Participant to revoke his or her election under the Plan and, in lieu thereof, to elect either to receive on a prospective basis coverage under another Benefit Package Option providing similar coverage, or to drop coverage if no similar Benefit Package Option is available. For purposes of this Plan, a "loss of coverage" means a complete loss of coverage under the Benefit Package Option or other coverage option.

c. Addition or Improvement of a Benefit Package Option. If the Plan adds a new Benefit Package Option or other Benefit option, or if coverage under an existing Benefit Package Option or other Benefit option is significantly improved during a Plan Year, the Plan shall permit Eligible Employees (whether or not they have previously made an election under the Plan or have previously elected the Benefit Package Option) to revoke their elections under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved Benefit Package Option or other Benefit option.

4. Change in Coverage Under Another Employer Plan. The Plan shall permit a Participant to make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same Employer or of another employer) if (i) the other plan permits participants to make an election change that would be permitted under this Section 4.3, or (ii) the Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other plan.

5. Loss of Coverage Under Other Group Health Coverage. The Plan shall permit a Participant to make an election on a prospective basis to add coverage under the Plan for the Participant, spouse, or dependent if the Participant, spouse, or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including (i) a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government (as defined in Section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization; (iii) a State health benefits risk pool; or (iv) a foreign government group health plan.

F. Special Requirements relating to the Family and Medical Leave Act. A Participant taking leave under the Family and Medical Leave Act (FMLA) may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

G. Revocation Due to Reduction in Hours of Service. In accordance with IRS Notice 2014-55, a Participant may prospectively revoke an election of coverage under a group health plan that is not a health flexible spending account plan and that provides minimum essential coverage (as defined in § 5000A(f)(1)) provided the following conditions are met:

1. The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Plan Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

H. Revocation Due to Enrollment in a Qualified Health Plan. In accordance with IRS Notice 2014-55, a Participant may prospectively revoke an election of coverage under a group health plan that is not a health flexible spending account plan and that provides minimum essential coverage (as defined in § 5000A(f)(1)) provided the following conditions are met:

1. The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the U.S. Department of Health and Human Services and any other applicable guidance, or the Participant

seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

2. The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Plan Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

I. Procedure for Making New Election. Except as otherwise provided, a Participant entitled to revoke an existing election and make a new election under this Section 4.3 may make a new election within 30 days of the occurrence of an event described herein as applicable, but only if the election under the new election is made on account of and is consistent with the event. The new election shall be effective for the balance of the period of coverage following the change of election unless a subsequent event allows for a further election change. Furthermore, except as provided for HIPAA special enrollment rights, in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable benefit commences later).

4.4 Rules Against Discrimination. The Administrator has the sole and absolute discretion to assure that the Plan does not violate applicable rules against discrimination in contributions or benefits contained in the Code, which discretion may include, without limiting the scope of the Administrator's discretion, modifying Participants' elections under their Salary Reduction Agreements, with or without the consent of the affected Participant. Actions of the Administrator to assure that the Plan does not violate rules against discrimination may be limited to that group of Participants in whose favor the Plan is found to be discriminatory, provided that all actions must be uniformly applied to all members of the affected group. The Administrator may not increase any Participant's reduction in Salary for the purpose of satisfying rules against discrimination.

4.5 Group Health Coverage: COBRA. Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under any group health plan sponsored by the Employer because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the group health plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and

limitations under COBRA. Contributions for COBRA coverage may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

5.0 BENEFITS

5.1 Benefit Schedule. Benefits payable under this Plan shall be those statutory taxable and non-taxable benefits set forth in the Benefit Schedule that is attached to this Plan as Exhibit A.

5.2 Covered Expenses. Benefits will be paid with regard to any Plan Year only for services and other covered expenses arising during that Plan Year. A service or covered expense is deemed to have arisen within the Plan Year that it is actually delivered, even if the Participant is billed, charged or pays for the service or covered expense after the end of the Plan Year. A Participant may submit claims for Benefits after the date of the Participant's employment termination, through the end of the third calendar month following the last day of the Plan Year within which the Participant terminates employment, for covered expenses incurred before the date of employment termination. Unless otherwise provided under the terms of a Benefit Plan or Policy, or otherwise required by law, no Benefits will be paid for expenses incurred by a Participant after the date the Participant terminates employment with the Employer.

5.3 Election of Benefits. For each Plan Year that a Participant wants to participate in the Plan, the Participant must file with the Administrator a written election of Benefits on a form furnished by the Administrator. The manner and place of filing will be determined under procedures established by the Administrator. The form will specify those Benefits from the Benefit Schedule that the Participant elects to receive during the Plan Year, and the amounts of each Benefit that the Participant will fund through a reduction in Salary or waiver of health insurance. Benefit elections may not be amended or revoked on or after the first day of the relevant Plan Year, for which they are made, except under the same circumstances that would permit the amendment or revocation of Salary Reduction Agreements, as described in Sections 4.2.C. and 4.3 of this Plan.

In addition to executing a Benefit election form, the Participant must provide all information and execute all applications and forms necessary to effectuate coverage under all Policies maintained by the Employer to provide the Benefits.

5.4 Benefit Payments. Benefit payments under this Plan will be made in the manner and subject to such conditions and restrictions as are contained in this Plan and the Policies or Benefit Plans providing the Benefits.

5.5 Cessation of Benefit Payments. Except with respect to accident or health plan coverage and group-term life insurance coverage, and unless otherwise provided by law, a Participant's eligibility to receive Benefits under this Plan will end if: (i) the Participant separates from service with the Employer; (ii) the Participant no longer satisfies the eligibility requirements for participation; (iii) the Participant ceases making required premium payments with respect to a Benefit under this Plan; or, (iv) this Plan is terminated. Termination of participation will automatically revoke the Participant's elections. A Participant whose eligibility to receive Benefits under this Plan ends for any of these reasons may not renew participation before the first day of the next Plan Year, and then only if the Participant satisfies all of the eligibility requirements for participation that are applicable to new Participants and makes necessary Benefit elections.

5.6 Forfeiture of Unused Benefits. Amounts of reduced Salary credited to Participants' accounts during a Plan Year that are not used to pay Benefits for eligible expenses incurred during that same Plan Year will be forfeited. This provision does not apply to a Health Savings Account (HSA) Contribution Benefit if such a Benefit is included in this Plan. In the Administrator's discretion, forfeited amounts may be used to: offset experience losses under a health care flexible spending account plan maintained in connection with this Plan; pay the administrative expenses of the Plan; reduce Employer contributions for the following Plan Year; or reduce Employer contributions funded through all Participants' Salary reductions for the following Plan Year. Forfeited amounts may not be paid to Participants in cash or otherwise made available to Participants.

6.0 ADMINISTRATION

6.1 Authority of the Administrator. Except for responsibilities reserved to the Employer, the administration of this Plan will be under the supervision of the Administrator. If ERISA should ever apply to this Plan, the Administrator will be the named fiduciary of the Plan with the discretionary authority to control and manage its operation and administration in all of its details, subject to applicable law, including without limitation:

A. Interpreting the terms and provisions of the Plan; provided that the Administrator may not amend or modify the terms of the Plan; and further provided that the Administrator is not by virtue of its powers under this Plan empowered to interpret any Beneficiary Plans or Policies.

B. Making and enforcing those written rules and procedures, and promulgating those forms, which it deems necessary for the efficient administration of the Plan.

C. Determining the rights of Participants under the Plan.

D. Paying the Premiums on behalf of all Participants entitled to such payments under the Plan and paying expenses incident to the administration of the Plan.

E. Conducting the appeal procedure set forth in Section 6.3.

F. Maintaining records and accounts pertaining to the Plan.

G. Appointing individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuarial counsel.

6.2 Claims. All claims for Benefits under this Plan must be submitted in accordance with this Plan and written procedures established by the Administrator, the Insurer (for Benefits provided under a Policy), or the administrator of the Benefit Plan (for Benefits provided under a Benefit Plan). The Administrator will make all determinations as to eligibility and the right of any Claimant to a Benefit, except Benefits provided under a Policy, in which case the Insurer will make those determinations under the terms of the Policy, or under a Benefit Plan, in which case the Benefit Plan administrator will make those determinations under the terms of the Benefit Plan. The Administrator may rely upon all information furnished to it by the Claimant, as the case may be, when making such determinations. Where benefits are to be provided by an Insurer or a Benefit Plan administrator, the Administrator may rely absolutely on the Insurer's or the administrator's determination regarding claims under the terms of the Policy.

In its sole and absolute discretion the Administrator may require, before paying all or a portion of a Benefit, that the recipient sign a receipt and a release of the claim in favor of the Administrator, the Insurer (if any), the Benefit Plan administrator (if any) and the Employer on a form furnished by or approved as to form by the party or parties being released.

6.3 Appeals of Denied Claims. If a claim is denied, totally or partially, the Administrator will provide the Claimant with a written denial stating (i) the specific reasons for the denial, (ii) references to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information the Claimant might be required to provide with an explanation of why it is needed, and (iv) an explanation of the Plan's appeal procedure. The written denial will be sent to the Claimant within 60 days after receipt of the claim by the Administrator. The 60 days may be extended for up to another 30 days if special circumstances warrant an extension of time. If an extension is needed by the Administrator to process the claim, the Claimant will be notified in writing before the beginning of the extension period. The notice will include an explanation of the circumstances requiring the extension of time and the date by which the Administrator expects to render a decision on the claim.

A Claimant may appeal the denial of a claim for Benefits by submitting a written request for a full and fair review to the Administrator. The Claimant may examine pertinent documents and submit pertinent issues and comments in writing; provided that neither the Employer nor the Administrator will be required by virtue of this provision to waive any privilege as to materials in their records or the records of their agents, including but not limited to the attorney-client privilege. The Claimant may have a representative throughout the appeals process who, if the Claimant chooses, may be a representative from the bargaining unit of which the Claimant is a member. The Claimant's written request for a review must be submitted within 60 days of the written notice of denial of the claim. The full and fair review will be completed and a

decision rendered by the Administrator within 60 days after receipt of the written request for review; provided that the time for rendering a decision may be extended upon written notice to the Claimant, if warranted by special circumstances, for up to 30 days from the date of the receipt of the written request for review. The Administrator's decision will be in writing and will include specific reasons for the decision, with specific references to the Plan provisions on which the decision is based. The decision of the Administrator will be final and binding; provided, however, that this procedure is not intended to limit other remedies that may be available to the Claimant under applicable statutes, common law or equity.

6.4 Administrator's Warranty. The Administrator warrants that all directions given, information furnished, or action taken by it shall be uniform and consistent with its interpretation of the provisions of the Plan authorizing or providing for such direction, information or action. The Administrator may rely upon all directions given by, information furnished by and actions taken by employees or agents of the Employer, which affect the Administrator's administration of this Plan, and is not required under this Plan to inquire into the propriety or correctness of any such direction, information or action. The Administrator is only responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan, and is not responsible or liable for any act or failure to act of an Employee of the Employer. Neither the Administrator nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

6.5 Compensation of Administrator. Those Employees performing the functions of the Administrator will not receive any compensation with respect to their performance of those duties, except as they may be entitled to Benefits as Participants under this Plan.

6.6 Records and Reports. The Administrator will keep complete and accurate records and accounts relating to the administration of this Plan, and will be responsible for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service for Code Section 125 plans. All records and accounts regarding the Plan will be the sole and exclusive property of the Employer and may not be audited or disclosed to Participants, Beneficiaries, any of their representatives, or any other third party except as permitted under this Plan, or as required by law or judicial order. After the close of each Plan Year the Administrator will provide each Participant with any statements or reports that are required by law. The records and accounts of the Plan may be disclosed to the Employer's auditors in connection with any regular or special audit of the Employer.

6.7 Incapacitated Payee. Subject to the terms of an applicable Benefit Plan or Policy, whenever, in the Administrator's opinion, a Participant or Beneficiary entitled to receive payment of a Benefit is under a legal disability or is incapacitated so that person appears to be unable to manage the person's own financial affairs, the Administrator may make payments to that person, or the Administrator may, but is not required to (unless required by law or judicial order), make payments to the person's legal representative or to a relative, or the Administrator may apply the payment for the benefit of the Participant or Beneficiary in such other manner as the Administrator considers advisable. The payment of a Benefit in accordance with this Section will constitute a complete discharge of any liability for the making of that payment.

6.8 Standard of Care. The Administrator will administer the Plan according to its terms, solely in the interests of the Participants and for the exclusive purpose of providing Benefits to Participants and defraying the reasonable expenses of administration. The Administrator will administer the Plan with that degree of care, skill, prudence and diligence that would be used by a prudent person acting in a like capacity and familiar with such matters, under the circumstances then prevailing.

6.9 Indemnification of the Administrator. The Administrator (so long as the Administrator is an employee or a committee of employees of the Employer) shall be held harmless and indemnified by the Employer against all claims, damages, judgments, settlements and other liabilities, including attorney's fees and expenses reasonably incurred in the defending of all claims, arising by reason of any act or failure to act made in good faith and consistent with the applicable standard of care in the administration of this Plan.

7.0 AMENDMENT AND TERMINATION

7.1 Amendment. This Plan is intended to be maintained indefinitely. Notwithstanding, the Employer may amend the Plan to comply with applicable law and regulations, provided that such an amendment does not cause the Plan to cease being maintained for the exclusive benefit of Participants, alter the requirements for eligibility to participate or benefit levels, reduce or eliminate a Participant's right to receive a benefit which the Participant already has a present right to receive, or increase the duties of the Administrator, unless the Administrator otherwise agrees. An amendment adopted by the Employer for the purpose of complying with applicable law and regulations shall be submitted by written notice to the appropriate representatives of all bargaining units whose members are eligible to participate in this Plan, at least 30 days before such amendment is to become effective. Any proposed amendment that will affect eligibility to participate in this Plan or benefit levels will not become effective without the consent of the bargaining units whose members are eligible to participate in the Plan. The Administrator will not be bound to the terms of any amendment until a true and accurate copy of the duly signed amendment has been delivered to the Administrator by the Employer.

7.2 Termination; Discontinuance of Benefits. Unless prohibited by applicable law, and with the consent of bargaining units whose members are eligible to participate in this Plan, the Employer may terminate or partially terminate the Plan at any time. If the Plan is terminated or partially terminated for any reason, amounts credited to accounts maintained under the Plan for Participants will continue to be applied for the exclusive benefit of the Participants. The termination of the Plan will not reduce or eliminate Participants' rights to reduce Salary earned before the date of the termination, nor affect the right of Participants to have Premiums paid under the provision of the Plan, but only to the extent that there are amounts credited to their accounts available for that purpose. Participants will not have the right to reduce, under this Plan, Salary earned after the date of the termination. Notice of a discontinuance or termination is not required except by the terms of any Policy, Benefit Plan or by law. The Insurer may cancel Policies according to their terms.

8.0 PROVISIONS FOR PARTICIPANTS ON FAMILY MEDICAL LEAVE

8.1 Participant's Rights under the Plan. Notwithstanding any other provisions of this Plan, a Participant who takes a leave of absence from the Employer under the federal Family and Medical Leave Act ("FMLA") will have the following rights under this Plan, provided the Employer is subject to the FMLA:

A. The Participant may elect to terminate participation in either or both of the health insurance and the health care flexible spending plan (if either or both of those benefits are provided under this Plan) during a Plan Year that the Participant is on FMLA leave, for the remaining portion of that Plan Year.

B. Upon returning to active service following an FMLA leave, a Participant whose participation in the health insurance or the health care flexible spending account plan (if any) was terminated during the leave, whether voluntarily by the Participant or due to nonpayment of amounts required to fund those benefits, may elect upon returning to active service to be reinstated to participation. The Participant's participation after returning from the FMLA leave will be at the same Benefit levels and on the same terms at which the Participant participated before the FMLA leave.

C. A Participant who is on FMLA leave and who continues to participate in this Plan during the leave may amend or revoke elections under this Plan in the same manner and with the same conditions as are applicable to all other Participants who are not on FMLA leave.

D. A Participant who is on an unpaid FMLA leave and who continues to participate in this Plan during the leave must continue to contribute the Participant's share of the cost of the Participant's health insurance coverage and the Participant's Health Care Reimbursement Account, based on the Participant's election of those Benefits, using one of the following payment options, as the Participant shall choose:

1. The Participant may pay, before beginning the FMLA leave period, the amounts due for the FMLA leave period. Prepaid contributions may be made before taxes by reducing taxable Salary (including any cashed-out unused sick days or vacations days), or after taxes from the Participant's other sources of funds.

2. The Participant may pay amounts due for the FMLA leave period on the same schedule as payment would have been made if the Participant were not on leave, or under any other payment schedule permitted under regulations promulgated by the U.S. Department of Labor. Contributions under this option may be made before taxes by reducing taxable Salary (including any cashed-out unused sick days or vacation days) that the Participant is due during the leave period, and provided that all plan requirements are satisfied, or after taxes from the Participant's other sources of funds.

3. If the Employer provides health Benefits to a Participant during an FMLA leave, but the Participant does not contribute to the cost of those Benefits during the leave period, the Employer's payment of the Participant's share of the costs will be treated as an advance

to the Participant which the Participant shall be required to repay to the Employer when the Participant returns to active service. Contributions by the Participant under this option may be made before taxes by reducing the Participant's Salary earned after the Participant returns from the FMLA leave, or after taxes from the Participant's other sources of funds.

E. A Participant who is on a paid FMLA leave, and who continues to participate in this Plan during the leave must continue to contribute the share of the cost of the Participant's health insurance coverage and the Participant's Health Care Reimbursement Account, based on the Participant's election of those Benefits, using the same method used during other types of paid leave authorized by the Employer.

F. In addition to the provisions contained in the preceding paragraphs, the following provisions apply specifically to Participants who have elected to participate in the health care flexible spending account plan (if such a benefit is available under this Plan) and who take an FMLA leave:

1. So long as the Participant continues to participate in the health care flexible spending account plan, the full amount of the elected coverage, as set forth on the Participant's Benefit Election Form, less any prior reimbursement, will be available to the Participant at all times during the FMLA leave period.

2. The Participant will not be entitled to receive reimbursements for claims incurred during any period during the FMLA leave that the Participant's participation in the health care flexible spending account plan terminates.

3. A Participant whose participation in the Plan terminates during the FMLA leave may reinstate participating upon returning to active service after the FMLA leave period for the remainder of the Plan Year; provided that the Participant may not be reimbursed for claims incurred during the period of the FMLA leave that participation was terminated. When the Participant reinstates participation, the Participant's coverage for the remainder of the Plan Year will be equal to the level of the Benefit chosen by the Participant for the Plan Year (as shown on the Participant's Benefit Election Form) prorated for the period during the FMLA leave that the Participant's participation was terminated, and reduced by reimbursements for claims incurred during the portion of the Plan Year preceding the FMLA leave.

8.2 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 4.3 will apply.

9.0 MISCELLANEOUS

9.1 Uniform Rules. The terms and conditions of this Plan and all rules promulgated by the Administrator under authority granted by this Plan will be interpreted and enforced in a uniform manner as to all similarly situated persons, and no action on the part of the Administrator or the Employer will discriminate in favor of highly compensated employees (as that term is defined in the Code and in regulations promulgated under the Code).

9.2 Construction. The Employer's intent and purpose in adopting this Plan is to establish a plan of welfare benefits consistent with relevant sections of the Internal Revenue Code. The Employer intends to comply fully with statutes and regulations governing wages, compensation, and fringe employment benefits. All questions arising in the construction and administration of this Plan must be resolved accordingly. This Plan is to be construed under the laws of the State of Michigan, except to the extent that the laws of the United States of America have superseded those state laws. The headings and subheadings in this Plan have been inserted for convenience only and are not to be construed as a part of this Plan. If a provision of this Plan is invalid, that invalidity does not affect other Plan provisions.

9.3 Non-alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of a Participant, before actually being received by the person entitled to the Benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to Benefits payable under this Plan will be void and of no effect as against the Plan, the Administrator or the Employer. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

9.4 Counterparts. This instrument may be executed in any number of counterparts, each of which shall be deemed an original.

MECOSTA-OSCEOLA INTERMEDIATE SCHOOL DISTRICT

Date:_____ By:_____

Its:_____

THE SECONDED RESTATED
MECOSTA-OSCEOLA INTERMEDIATE SCHOOL DISTRICT
CAFETERIA PLAN
[Restated Effective _____,2020]

EXHIBIT A

BENEFIT SCHEDULE

Medical Plan Coverage

Each Participant who wants coverage under the insured Medical Plan maintained by the Employer for a Plan Year will receive coverage under the Policy or Policies maintained by the Employer to provide such coverage as designated by the Participant in the election form or forms executed by the Participant for the Plan Year under the terms of such Policy or Policies. The coverage available to the Participant will be in accordance with the pertinent provisions of the Collective Bargaining Agreement between the Employer and the bargaining unit that represents the Participant, or in the case of non-organized Participants, in accordance with the terms of the Participant's employment with the Employer.

Medical Insurance Premium, Employee Portion.

The Salary of each Participant electing this Benefit will be reduced in accordance with a Salary Reduction Agreement to pay the Participant's contribution to the Premium under the Policy or Policies maintained by the Employer to provide health coverage in the amount, when added to the Employer's portion, that is required for the coverage designated by the Participant in the Participant's election form, and amounts so reduced in each pay period during the relevant Plan Year will be credited to the Participant's Medical Insurance Premium Account. Premiums will be paid from the Participant's Medical Insurance Premium Account in accordance with the terms of the Policy. Amounts credited to a Participant's Medical Insurance Premium Account may only be used to pay medical insurance Premiums, and any amounts credited to that Account within a Plan Year that are not so used before the end of that Plan Year will be deemed forfeited. The Plan may not pay Premiums for individual health insurance policies that provide major medical coverage.

Waiver of Health Insurance; Cash Option

Each Participant who does not want coverage under the Employer's insured medical plan may elect to not receive such coverage for a Plan Year by executing a Waiver form provided by the Administrator within the relevant Election Period, including a certification that the Participant (or spouse and dependents) have alternate medical coverage providing minimum essential coverage as defined under the Affordable Care Act (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the waiver applies. A Participant who elects to waive coverage under the Employer's insured medical plan will receive cash in lieu of health insurance coverage in an amount and at the times determined by referencing the pertinent provisions of the Collective Bargaining Agreement between the Employer and the bargaining unit that represents the Participant, or in the case of non-organized

Participants, the terms of the Participant's employment with the Employer. Unless otherwise provided, a Participant's waiver of health insurance shall apply to major medical coverage for which the Participant is eligible, and shall not apply to other insured benefits such as dental or vision coverage. Notwithstanding the foregoing, this Benefit may not be offered to an Employee who is eligible for coverage by Medicare or Tricare, unless the Employee provides satisfactory proof of primary medical coverage other than by Medicare or Tricare, such as under a group health plan sponsored by the Employer of the Employee's spouse, or to an Employee who is covered by Medicaid or VA health care.

Medical Expense Reimbursement Plan

The Salary of each Participant electing this Benefit will be reduced in accordance with a Salary Reduction Agreement to fund the Participant's Health Care Reimbursement Account established for the Participant under the Employer's Medical Expense Reimbursement Plan. The amount and payment of Benefits will be determined under the Medical Expense Reimbursement Plan. Eligible Employees who participate in a Health Savings Account may participate in the Medical Expense Reimbursement Plan on a limited-purpose basis.

Dependent Care Reimbursement Plan

The Salary of each Participant electing this Benefit will be reduced in accordance with a Salary Reduction Agreement to fund the Participant's Dependent Care Reimbursement Account established for the Participant under the Employer's Dependent Care Reimbursement Plan. The amount and payment of Benefits will be determined under the Dependent Care Reimbursement Plan.

Health Savings Account (HSA) Contributions

a. A Participant who is HSA-eligible as provided in Code Section 223(c)(1) can elect to pay HSA contributions on a pre-tax basis via a Salary Reduction Agreement. The Participant's HSA must be established and maintained outside the Plan with a trustee/custodian to whom the Employer can forward contributions derived from the Participant's Salary Reduction, to be deposited into the Participant's HSA. Notwithstanding anything to the contrary contained in the Plan regarding permitted election changes, the Participant may increase, decrease or revoke prospectively the Participant's HSA contribution election at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

b. A Participant is HSA-eligible, with respect to any month, if:

   (i) **s**uch Participant is covered under a high deductible health plan as of the 1st day of such month, and

   (ii) such individual is not, while covered under a high deductible health plan, covered under any health plan:

(1) which is not a high deductible health plan, and

(2) which provides coverage for any benefit which is covered under the high deductible health plan (other than disregarded coverage).

c. A Participant may elect up to the maximum allowable contribution, as provided by Code Section 223 (adjusted for cost-of-living) for the Participant's coverage level under the High Deductible Health Plan sponsored by the Employer; provided, however, that the maximum annual contribution shall be:

(i) reduced by any Employer contribution (other than the contributions made pursuant to the Participant's Salary Reduction Agreement) made on the Participant's behalf, if any; and

(ii) prorated for the number of months in which the Participant is an HSA-Eligible Individual.

Subject the terms and conditions set forth in this paragraph, the Employer may agree to (but is not required to) accelerate amounts elected by an Employee as elective contributions (pursuant to the Participant's Salary Reduction Agreement) into the employee's HSA, up to the maximum amount elected by the Participant. If the Employer accelerates contributions as to any Participant, then the Employer shall offer accelerated contributions to all HSA Participants on the same terms and conditions. The terms and conditions upon which the Employer may make accelerated contributions shall include (without limitation):

(i) The Employer will not be required to make an accelerated contribution on behalf of a Participant more than one time per Plan Year and the Employer shall determine, in its discretion, the timing during the Plan Year of the actual deposit of the accelerated contribution into the Employee's HSA.

(ii) The Employer shall not be obligated to make any additional accelerated contribution into the Participant's HSA during a Plan Year in which the Employer previously made an accelerated contribution, even if the Participant modifies the Participant's HSA election during the Plan Year to increase the amount of the Participant's HSA contribution.

(iii) The availability of an accelerated contribution to a Participant's HSA made by the Employer for distribution to or on behalf of the Participant or the Participant's spouse or dependents shall not be restricted by the Employer.

(iv) The Participant shall repay the entire amount of the accelerated contribution by the end of the Plan Year through the pre-tax salary reduction elected by the Participant under the Participant's Salary Reduction Agreement. The Participant must agree that if the Participant does not repay the Employer for the entire amount of the accelerated contribution by the end of the Plan Year, then the Employer may withhold and recoup the deficiency from compensation due and owing the

Participant from the Employer, or which becomes due and owing to the Participant from the Employer in the future (including but not limited to amounts that become payable on separation from employment); provided that such withholding shall not violate any applicable state or federal law. If, however, the Participant lacks sufficient compensation to repay the entire amount of a deficiency, then the Participant shall remain liable to the Employer in the amount of the deficiency, and the Employer reserves the right in its sole discretion to use any legal means that the Employer deems appropriate to collect the unpaid deficiency (plus interest and attorney fees), which may include the commencement of judicial proceedings.

(v) The Participant shall release the Employer from any liability arising in connection with any claim by the Participant, or the Participant's spouse or dependents for any benefits or coverage under the Participant's HSA and shall agree to defend and indemnify the Employer, the Administrator, and all employees and agents of each of them, from any liability, loss, damages, costs or expenses (including but not limited to attorneys' fees) arising in connection with benefits or coverage in any way relating to the Participant's HSA.

(vi) Before the Employer will accelerate any contributions into a Participant's HSA, the Participant shall execute an agreement incorporating the terms and conditions set forth herein, and such other terms and conditions the Administrator reasonably requires.

d. The Plan Administrator shall maintain records of contributions forwarded to the HSA trustee/custodian of each Participant's HSA. The Plan Administrator will not, however, create a separate fund or otherwise segregate assets for this purpose. Other than forwarding contributions through its payroll system to each Participant's HSA trustee/custodian, the Employer has no authority or control over the funds deposited in a HSA. Furthermore, the establishment of each Participant's HSA is completely voluntary on the part of the Participant and the Employer does not:

(i) limit the ability of the Participant to move his/her funds to other HSAs, beyond the restrictions imposed by the Code;

(ii) impose conditions on utilization of HSA funds beyond those permitted under the Code;

(iii) make or influence the investment decisions with respect to funds contributed to an HSA;

(iv) represent that the Participant's HSA is an employee welfare benefit plan established or maintained by the Employer;

(v) have any authority or responsibility whatsoever to determine whether distributions from the Participant's HSA are for qualified medical expenses, because only the

Participant or the account beneficiary may determine how HSA distributions will be used; or

(vi) receive any payment or compensation in connection with an HSA.

e. The tax treatment of Participants' contributions to their HSAs is governed by Code Section 223.

Cash.

Participants not electing any of the nontaxable Benefits provided under this Plan will receive Salary, in cash, without any reduction.