SUMMARY DESCRIPTION

OF THE

DEXTER COMMUNITY SCHOOLS
FLEXIBLE BENEFITS PLAN

Effective July 1, 2015

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INTRODUCTION

Your employer, Dexter Community Schools ("Employer"), is pleased to sponsor an employee benefit program known as the Dexter Community Schools Flexible Benefits Plan (the "Plan") for its employees. Under federal tax laws, it is also known as a "cafeteria plan." The Employer provides you with the opportunity to use pre-tax dollars to pay certain benefit costs by entering into a salary reduction arrangement. This arrangement helps you because the benefits you elect are nontaxable; you should save social security and income taxes on the amount of your salary reduction.

This summary describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. To make use of this Plan, be sure to proceed through this booklet carefully so that you can make informed decisions that are right for you.

If there is a conflict between the underlying Plan and this summary, the intention is for the Plan documents to govern.

PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reduction to choose (and pay for) certain benefits made available by your Employer.

1.2 When did the Plan take effect?

This Plan became effective July 1, 2015. The Plan operates on a Plan Year running from January 1st through December 31st. The Plan Year beginning on July 1, 2015, is a short Plan Year that ends on December 31, 2015.

1.3 What benefits are offered through the Plan?

This Plan makes the following optional benefits available:

Non-Reimbursement:

- **Group Medical Benefits**
  - The group medical benefit allows a Participant to pay the employee's share of the cost for medical coverage made available by the Employer with pre-tax dollars through salary reduction and, in some cases, Employer Contributions.
- **Group Dental Benefits**
  - The group dental benefit allows a Participant to pay the employee's share of the cost for dental coverage made available by the Employer with pre-tax dollars through salary reduction.
- **Group Vision Benefits**
  - The group vision benefit allows a Participant to pay the employee's share of the cost for vision coverage made available by the Employer with pre-tax dollars through salary reduction.
- **HSA Contribution Feature**
  - The HSA Contribution Feature allows a Participant to make contributions to an HSA with pre-tax dollars through salary reduction.
- **Cash Payment**
  - The cash payment benefit allows a Participant to receive cash in lieu of using the Employer Contribution to pay for other benefits provided through the Plan. Cash payments are taxable to the Participant.

Reimbursement:

- **Dependent Care Expense Reimbursement Plan**
  - The dependent care reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction that may be used to reimburse the Participant for eligible dependent care expenses.
- **Medical Expense Reimbursement Plan**
  - The medical expense reimbursement benefit allows a Participant to fund an account with pre-tax dollars through salary reduction which may be used to reimburse the Participant for eligible medical expenses.

1.4 Who can participate in the Plan?

Each employee who is employed in the following classification is eligible to participate in the Plan:

(a) DEA (teachers): All Employees are eligible

(b) DAA (Administrators): All Employees are eligible

(c) Individual Contracts: Full-time Employees working forty (40) hours per week

(d) Hourly Support Personnel as follows:

(1) Secretaries: Employees working thirty (30) or more hours per week during school year

(2) Building & Grounds: Employees working thirty (30) or more hours per week

(3) Technology: Employees working thirty (30) or more hours per week

(e) Food & Nutrition: Employees working fifteen (15) or more hours per week

(f) Bus Drivers: All Employees are eligible except trainees and substitutes

(g) Other Hourly Workers: Full-time Employees working forty (40) hours per week

In addition, notwithstanding anything herein to the contrary, any employee who is enrolled in the Employer's group medical plan shall be eligible to participate in the Group Medical Benefits portion of this Plan.

These employees are called "Eligible Employees". Those Eligible Employees who actually participate in the Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of the exceptions.

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

1.5 When do I become a Participant and how long does participation last?

Participation begins on the first of the month following the date on which the Employee satisfies the definition of Eligible Employee or, if later, the first day of the first pay period following your completion and submission of the required enrollment forms. You must submit the enrollment forms within the time period established and communicated to you by the Plan Administrator.

In some cases, if you do not complete the enrollment forms within that time period, you must wait until the start of a Plan Year to begin participation. However, with respect to insurance and insurance-type benefits (e.g., group medical or group dental), you will be deemed to have elected to participate in this Plan for the purpose of paying your share of the cost of such coverage through salary reduction unless you specifically elect not to participate

with respect to such coverage. Such an election must be in writing and must be received by the Plan Administrator prior to the date your participation in the Plan would otherwise begin.

As a condition to participation in the Plan, you must also:

(a) Observe all Plan rules and regulations;

(b) Agree to inquiries by the Plan Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan;

(c) Submit to the Plan Administrator all notifications, reports, bills, and other information that the Plan Administrator may reasonably require; and

(d) Agree to repay any overpayments or incorrect payments you receive from the Plan.

Participation continues until you elect not to participate, you are no longer an Eligible Employee, the Plan terminates, your contributions cease, or your participation is terminated for cause.

1.6 How do I enroll and make benefit elections?

(a) **Generally**. The annual enrollment period begins and ends on or before the last day of each Plan Year. The Plan Administrator will provide you with the forms necessary to enroll and make elections, including information about the costs of the various optional benefits.

(b) **Initial Enrollment**. An Eligible Employee who does not make an election during the initial enrollment period must wait until the next annual enrollment period to begin participation, except that you will be deemed to have elected to pay through salary reduction any portion of the cost for which you are responsible for the insurance and insurance-type coverages in which you have enrolled.

(c) **Annual Enrollment**. A Participant who does not make an election during the annual enrollment period shall be deemed to have elected to pay through salary reduction any portion of the cost for which you are responsible for insurance and insurance-type coverages in which you have enrolled, and shall be deemed to have elected not to participate with respect to other benefits (i.e., reimbursement accounts).

Note: Enrollment forms received after the close of the enrollment period shall be void.

The maximum election available under this Plan is the sum of the employee portion of the cost of coverage available through the Employer under the insurance or insurance-type options, and the maximum election permitted under the other Optional Benefits listed in Section 1.3.

Caution: With limited exceptions, once made, elections remain in effect for the entire Plan Year. The exceptions are described below at Section 1.7.

1.7 Can I change my election during the Plan Year?

Generally, you cannot change your election regarding participation in the Plan or the benefits you have selected during the Plan Year. You may change your elections only during the annual enrollment period, and then, only for the coming Plan Year. However, your elections will terminate automatically if you cease to be eligible to participate in the Plan. In addition, there are several other exceptions to this general rule.

Caution: The circumstances in which you are allowed to change your election, as further described below, are based upon the facts and circumstances of each particular situation. The descriptions of the rules below are general in nature. If you have questions regarding the application of the rules to your specific fact situation, please contact the Plan Administrator immediately. Any request to change your election must be within the deadline described below.

Note: The exceptions to the general rule that elections are irrevocable for the Plan Year are determined under regulations issued by the IRS.

Note: The IRS recognizes only marriages that are valid under applicable state law. Accordingly, a reference to marital status or spouse in this Section 1.7 is applicable only if you are married and the marriage is valid under applicable state law.

Note: For purposes of this Section 1.7, if the election relates to an Optional Benefit involving health benefits (e.g., Group Medical Plan, Group Dental Plan, Group Vision Plan, Medical Expense Reimbursement Plan), the term "dependent" means a "tax dependent" as defined below in Section 1.15. If the election relates to the Dependent Care Expense Reimbursement Plan, the term "dependent" means a "qualifying individual" as defined below in Section 5.4.

(a) **Change in Status.** You may change or revoke your previous election during the Plan Year if one or more of the following changes in status occur:

(1) a change in your legal marital status, including marriage, divorce, death of your spouse, legal separation or annulment;

Note: A change in the status of a domestic partnership is not a change in status.

(2) a change in the number of your dependents, including birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;

(3) any of the following events that change your employment status or the employment status of your spouse or dependent: termination or commencement of employment, a reduction or increase in hours worked, a switch between part-time and full-time, a strike or lockout, a change in worksite, commencement or return from an unpaid leave of absence, a switch between hourly and salaried, a switch between union and non-union, or any similar event;

(4) an event causing a dependent to satisfy or cease to satisfy the eligibility requirements applicable under a plan provided or paid for through this Plan; or

(5) a change in place of residence for you, your spouse or your dependent.

A change or revocation shall be allowed in these circumstances only if such change or revocation is made on account of, and corresponds with, the change in status and the change in status affects eligibility for coverage under a plan sponsored by the Employer or another employer (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change or revocation satisfies the general consistency requirement.

Example 1: An employee enrolls in single coverage under the Employer's Group Medical Plan and elects to pay the cost of that coverage through the Plan. The employee also elects to participate in the Medical Expense Reimbursement Plan. During the Plan Year, the employee gets married. If the employee enrolls his or her new spouse in the Group Medical Plan, the employee may change his or her election to pay the increased cost of that coverage through the Plan. In addition, the employee may increase his or her election under the Medical Expense Reimbursement Plan.

A requested change or revocation must also satisfy the following specific consistency requirements in order for you to be able to alter your election based on the change in status:

(1) **Loss of Dependent Eligibility.** For a change in status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, you may elect to change your election only to reflect the cancellation of group health plan coverage for the affected spouse or dependent. Canceling coverage for any other individual under these circumstances fails to correspond with that change in status. For example, if you have elected group medical coverage for you, your spouse, and your child, and you divorce during the Plan Year, you may drop your ex-spouse from the coverage and make an election change under this Plan to reflect the reduced cost of coverage. However, you would not be allowed to change your election to reflect the reduced cost attributable to dropping coverage for yourself or your child.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan**. If you, your spouse, or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital status or a change in employment status, you may elect to terminate or decrease your election under this Plan on account of that change in status only if coverage becomes effective or is increased under the other employer's plan.

(3) **Dependent Care Expense Reimbursement Plan**. With respect to the Dependent Care Expense Reimbursement Plan, you may change or terminate your election only if (i) the change or termination is made on account of and corresponds with a change in status that affects eligibility for coverage under the Flexible Benefit Dependent Care Expense Reimbursement Plan; or (ii) the election change is on account of and corresponds with a change in status that affects eligibility of dependent care expenses for the tax exclusion available under the Internal Revenue Code. For example, if your child attains age 13 during the Plan Year, you may terminate your election under the Dependent Care Expense Reimbursement Plan because your child is no longer eligible to participate in the Dependent Care Expense Reimbursement Plan (i.e., she is no longer a qualifying individual).

(4) **COBRA Coverage**. If you, your spouse, and/or your dependent elects COBRA continuation coverage (or similar health plan continuation coverage under state law) with respect to a group health plan sponsored by the Employer, you may increase your election for the purpose of paying the cost of the increased premium for such continuation coverage, provided you are still eligible under the Plan and are receiving compensation from the Employer.

(b) **Other Change in Election Events.** You may also change or revoke your previous election during the Plan Year in the following circumstances.

(1) **HIPAA Special Enrollment Rights**. In certain cases, individuals are allowed to enroll in the Employer's Group Medical Plan pursuant to HIPAA special enrollment at times other than

open enrollment. (Please refer to the Group Medical Plan document for additional information regarding HIPAA special enrollment.) If you, your spouse, and/or your dependent enroll in the Group Medical Plan pursuant to HIPAA special enrollment, you may make a new election under the Plan to pay the cost of that new or increased coverage. For purposes of this provision an election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right.

(2) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires you to cover your child (including a foster child who is your dependent) under the Group Medical Plan, Group Dental Plan, Group Vision Plan, or the Medical Expense Reimbursement Plan, you may change your election to pay the increased cost of coverage incurred to add the dependent child to your coverage. If an Order requires another individual to provide health coverage for your child (including a foster child who is your dependent) and the child is currently enrolled in the Group Medical Plan, Group Dental Plan, Group Vision Plan, or the Medical Expense Reimbursement Plan, you may terminate coverage for the child and change your election to reflect the reduced cost of coverage (if any), provided the other individual actually provides coverage to the child as required by the Order. For example, if you have enrolled in single coverage under the Group Medical Plan, become divorced during the Plan Year, and are ordered to provide coverage to your child following the divorce, you may increase your election to pay the additional cost of the child's coverage under the Group Medical Plan.

(3) **Medicare and Medicaid**. If you, your spouse, or your dependent is enrolled in the Group Medical Plan, Group Dental Plan, or Group Vision Plan, such individual subsequently enrolls in Medicare or Medicaid, and such individual's coverage under the Employer's plan is cancelled, you may change your election to reflect the reduced cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also reduce or cancel your election with respect to the Medical Expense Reimbursement Plan. Further, if you, your spouse, or your dependent has been enrolled Medicare or Medicaid, such individual loses eligibility for such coverage, and such individual enrolls in the Group Medical Plan, Group Dental Plan, or Group Vision Plan you may change your election to reflect the increased cost of coverage (if any) under the applicable Employer-sponsored group health plan. You may also make or increase your election with respect to the Medical Expense Reimbursement Plan.

(4) **Change in Cost**.

Note: Although the Plan Administrator will be aware of an increase or decrease in the cost of many Optional Benefits, you will need to notify the Plan Administrator of any changes to the cost of benefits under the Dependent Care Expense Reimbursement Plan.

Note: The events described in this subsection allow you to change your elections for all optional benefits ***except*** the Medical Expense Reimbursement Plan. You are not able to change your Medical Expense Reimbursement Plan election due to a change in cost/change in coverage.

(i) **Automatic Increase or Decrease for Insignificant Cost Changes**. If the cost of coverage increases or decreases during a Plan Year by an insignificant amount, then your election to pay the cost of such coverage through the Plan shall be

automatically increased or decreased to reflect such change in the cost. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(ii) **Significant Cost Increases**. If the Plan Administrator determines that the cost of coverage significantly increases during a Plan Year, you may either: (1) increase in your election to pay the additional cost; (2) enroll in another benefit package option providing similar coverage and change your election (if necessary) to pay the cost of that option through the Plan; or (3) cancel the underlying coverage and revoke your election to pay the cost of that coverage through the Plan if no other benefit package option providing similar coverage is available. For example, if the cost of one option under the Group Medical Plan significantly increases during the Plan Year, you may increase your election to pay the increased cost or enroll in another option available under the Group Medical Plan and change your election to correspond to the new cost of Group Medical Plan coverage. If there is only Group Medical Plan option, you may increase your election to pay the increased cost of that option or cancel Group Medical Plan coverage and revoke your election to pay for that coverage through the Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(iii) **Significant Cost Decrease.** If the Plan Administrator determines that the cost of coverage significantly decreases during a Plan Year: (a) you may enroll in the coverage and make or change your election to pay the cost of such coverage through the Plan; or (b) if you are already enrolled in the underlying coverage and are paying the cost of such coverage through the Plan, the Plan Administrator will automatically decrease your election to pay the cost of such coverage in accordance with the cost decrease.

(A) **Cause of Cost Changes.** For purposes of this rule, a change in cost allowing an election change can result from action taken by you (e.g., switching between full-time and part-time employment) or your employer (e.g., changing the amount of employer contribution toward the cost of coverage).

(B) **Application to Dependent Care Reimbursement Plan.** This rule does not apply to changes in cost if the dependent care provider is your relative.

(5) **Change in Coverage.**

> **Note:** The events described in this subsection allow you to change your elections for all optional benefits ***except*** the Medical Expense Reimbursement Plan. You are not able to change your Medical Expense Reimbursement Plan election due to a change in cost/change in coverage.

(i) **Significant Curtailment**. If the Plan Administrator determines that your coverage, or the coverage of your spouse or dependent, is significantly curtailed during a Plan Year, you may enroll in another benefit package option providing similar coverage and make a corresponding election change to pay for that new coverage through the Plan. Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to all participants in general (e.g., a significant increase in the deductible, copays, or out-of-pocket maximum applicable under the plan). The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(ii) **Loss of Coverage.** If the Plan Administrator determines that your coverage, or the coverage of your spouse or dependent, is lost during a Plan Year, you may: (1) enroll in another option providing similar coverage and make a corresponding election change to pay for that new coverage through the Plan; or (2) if no other option providing similar coverage is available, cancel the underlying coverage and revoke your election to pay the cost of such coverage through this Plan. Coverage is deemed "lost" only if there is a complete loss of coverage (e.g., the benefit plan option is eliminated or an annual or lifetime maximum is reached) or other fundamental loss of coverage (e.g., a substantial decrease in the health care providers available under the option or a reduction in benefits for a specific type of medical condition with respect to which you or your spouse or dependent is currently receiving treatment. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a "loss" has occurred, and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

> **Application to Dependent Care Expense Reimbursement Plan.** This rule allows you to change your election under the Dependent Care Expense Reimbursement Plan to reflect changes regarding your dependent care provider, including: (1) the termination of one provider and the hiring of another provider; and (2) the termination of a provider because a relative becomes available to care for your child at no cost. You will need to notify the Plan Administrator of any such change in coverage under the Dependent Care Expense Reimbursement Plan.

(iii) **Addition or Improvement of an Optional Benefit**. If during a Plan Year, a new plan or plan option is offered, or if coverage under an existing plan or option is significantly improved, you may enroll in the new or improved coverage and make or change your election to pay the cost of such coverage through the Plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether an Optional Benefit has been "significantly improved" based upon all the surrounding facts and circumstances.

(iv) **Change Under Another Employer-Sponsored Plan**. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer or a plan of another employer) if: (i) the other plan permits its participants to make an election change that would be permitted under the prevailing IRS guidance; or (ii) the Plan Year of this Plan is different from the plan year under the other plan. For example, if your spouse drops your coverage during open enrollment under his or her employer's group medical plan and you enroll in the Employer's Group Medical Plan, you may make or change your election to pay for such coverage through the Plan.

(v) **Loss of Governmental or Educational Coverage**. If you add coverage under an Employer-sponsored group health plan (e.g., the Group Medical Plan, Group Dental Plan, or Group Vision Plan) for yourself or your spouse or dependent because such individual has lost coverage under any health coverage sponsored by a governmental or educational institution (including, but not limited to, the following: a state children's health insurance program ("SCHIP"); a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government health plan), you may make or change your election to pay the cost of such coverage under the Plan.

(vi) **Enrollment in Marketplace Coverage.**

(A) If you have made an election to pay for Group Medical Plan coverage, you may revoke that election if the following conditions are satisfied:

(I) You either (1) are eligible to enroll in a qualified health plan through a public insurance exchange (the "Marketplace") via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(II) You cancel coverage under the Group Medical Plan in accordance with the requirements of that plan; and

(III) You, and any related individuals who were also enrolled in the Group Medical Plan, have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which coverage under the Group Medical Plan was effective (i.e., there is no break in coverage). The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (III) are met.

(B) If you have made an election to pay for Group Medical Plan coverage, you may reduce that election if the following conditions are satisfied:

(I) Your spouse and/or dependents either (1) are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (as provided in any guidance issued by the

Department of Health and Human Services or any other applicable guidance), or (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(II) You cancel coverage under the Group Medical Plan for such spouse and/or dependents in accordance with the requirements of that plan; and

(III) Such spouse and/or dependents have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which the coverage under the Group Medical Plan was effective (i.e., there is no break in coverage). The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (III) are met.

(6) **Reduction in Hours Without Loss of Eligibility.** If you have made an election to pay for Group Medical Plan coverage, you may revoke that election if the following conditions are satisfied:

(i) You have been in an employment status under which you were reasonably expected to average at least thirty (30) hours of service per week;

(ii) You have experienced a change in employment status such that you will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless will remain eligible for the Group Medical Plan;

(iii) You cancel coverage under the Group Medical Plan in accordance with the requirements of that plan; and

(iv) You, and any related individuals who were also enrolled in the Group Medical Plan, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that will be effective no later than the first day of the second month following the month in which coverage under the Group Medical Plan ends. The Plan Administrator may rely on your reasonable representation that the requirements of this paragraph (iv) are met.

(5) **Family and Medical Leave Act.** If you take a leave governed by the Family and Medical Leave Act of 1993 ("FMLA"), you may revoke or change an election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

(6) **Special Rule for HSA Contribution Feature**. You may change your election with respect to the HSA Contribution Feature prospectively on a monthly basis. You may also revoke your election with respect to the HSA Contribution Feature prospectively if you become ineligible to make or have made HSA contributions under the HSA Contribution Feature.

(7) **Other**. The Plan Administrator shall have the discretion to allow a change to, or termination of, an election to the extent such change or termination is the result of any other situation informally recognized by the IRS as providing an exception to the general rule that elections are irrevocable (e.g., corrections of mistakes, failure to satisfy underwriting). If the Plan Administrator determines before or during any Plan Year that

the Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of your election downward with or without your consent.

(c) **Procedure for Requesting a Change.** If a change in election is allowed under the foregoing rules, you must typically inform the Plan Administrator of your new election within thirty (30) days of the occurrence of the event allowing the change. However, if the election relates to the Dependent Care Expense Reimbursement Plan and is on account of the birth, adoption, or placement for adoption of a new child, you may have additional time to inform the Plan Administrator of the new election. Please contact the Plan Administrator for additional information.

Your election change must be on account of and consistent with the status change that has occurred. In general, that means the event must result in a change in coverage that changes the cost.

Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days, provided it applies to compensation not yet currently available. All other new elections shall be effective prospectively immediately following the date the Participant files the new election with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

1.8 Who holds the funds I have set aside under the Plan?

The funds you contribute by means of salary reduction to pay the Employee portion of the cost of coverage under the insured options will be held by the Employer until the Employer pays for such coverage. The funds you contribute by means of salary reduction to reimburse eligible medical expenses and eligible dependent care expenses are also held by the Employer until paid to you as a reimbursement.

All payments are made from the general assets of the Employer. There is no separate trust.

1.9 What if I terminate my employment during the Plan Year?

If your employment with the Employer terminates during the Plan Year, your active participation with this Plan ceases. You will not be able to make any more contributions for the benefits elected under this Plan, other than as may be permitted under the continuation coverage provisions that apply to group health plan coverages.

If you are rehired after thirty (30) days following a termination of employment and again become a Participant, you will have two "periods of coverage" – that period prior to the termination of employment and that period following the re-employment. Expenses incurred prior to the termination of employment shall be subject to the election in effect upon termination. Upon re-employment, you shall have an opportunity to make a new election and expenses incurred after re-employment shall be subject to the election made upon re-employment.

If you are rehired within thirty (30) days following a termination of employment, your election in effect prior to the termination of employment will be reinstated upon re-employment.

1.10 Will I have any administrative costs under the Plan?

No. The entire cost of administering the Plan is paid by the Employer, from Plan forfeitures, or a combination of both.

1.11 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the optional benefits) indefinitely, it has the right to amend or terminate the Plan in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended or terminated accordingly. You will be informed if any changes are made to the Plan.

1.12 Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are intended to not be currently taxable to you. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment of any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax advisor.

You should realize that any medical expense you pay or are reimbursed on a pre-tax basis under this Plan cannot be claimed as a medical expense deduction on your income tax return. However, unless your medical expenses exceed ten percent (10%) of your adjusted gross income, you are not permitted to use the deduction anyway.

Any reimbursements made with pre-tax dollars for dependent care expenses affect your ability to claim the dependent care credit. This is explained further in the description of the Dependent Care Expense Reimbursement Plan later in this summary.

If you receive a cash payment of any of the Employer Contribution, the cash payment will be taxable to you. See Article VIII for additional information.

If the Plan Administrator determines before or during any Plan Year the Plan or an Optional Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a re-characterization within the Plan Year of benefits provided under the Plan as taxable income, with or without consent of the affected Participants.

1.13 What is the impact on my Social Security benefits?

Because less Social Security taxes are withheld from your pay, your Social Security benefits may be affected at your retirement. However, contributions to the Plan usually have a minimal effect on your Social Security benefits.

1.14 What contributions are made to the Plan?

(a) **Employer Contribution**. The Employer may make a fixed dollar contribution per Plan Year per Participant (the "Employer Contribution"). The amount of the Employer Contribution may change from year to year as announced by the Employer prior to the Plan Year start. The Employer may designate different amounts for different groups of Eligible Employees. The Employer Contribution is used to provide a Cash Payment to certain Participants who waive Group Medical Benefits as further described in Part VIII. No Employer Contribution shall be credited to any Employee during a period of leave of absence, whether authorized or unauthorized, unless required by the Family Medical Leave Act ("FMLA").

(b) **Salary Reduction Contributions**. To the extent the cost of an Optional Benefit exceeds the Employer Contribution (if any), you may elect in accordance with the election procedures described in Section 1.6 to receive your full compensation in cash, or to have a portion of such compensation applied by the Employer toward your share of the cost of Optional Benefits. If so elected, your compensation will be reduced, and an amount equal to the reduction will be allocated by the Employer to the Optional Benefits you have designated. Your compensation shall be reduced by pro-rata amounts of your total salary reduction election. Salary reduction is done on a pre-tax basis before any withholdings have been made. The frequency of salary reduction contributions shall be every payroll period. Notwithstanding anything in the Plan to the contrary, if coverage under an Optional Benefit extends to the last day of the month in which your employment terminates, if necessary, additional salary reduction contributions shall be taken from your final pay check to pay for the coverage provided during the period of time following the date on which your employment terminates.

(c) **Salary Deduction Contributions.** Sometimes the Internal Revenue Code or your Employer does not allow payment with pre-tax dollars. Payments which may be made with after-tax dollars may be paid through a salary deduction agreement. A salary deduction agreement provides for a payroll deduction to be made throughout a Plan Year out of your compensation ***after*** taxes and withholdings have been made.

1.15 What if coverage is provided to someone other than your spouse and tax dependents?

If you participate in an Optional Benefit that covers a dependent who is not your "spouse" or "tax dependent," the entire cost of coverage for Optional Benefits for which you are responsible shall be paid pre-tax through this Plan and the fair market value of the coverage for that Dependent shall be imputed as income to you as the coverage is provided. This provision applies regardless of whether the cost of coverage is paid by salary reduction or by the Employer.

For purposes of this Plan, **"spouse"** means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Plan, **"tax dependent"** generally includes an individual who satisfies the requirements of paragraph (a), (b), or (c) below:

(a) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(2) will not attain age 27 during the relevant calendar year.

(b) An individual who:

(1) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(2) has the same principal place of abode as you for at least one-half of the relevant year;

(3) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(4) did not provide over half of his/her own support during the relevant year;

(5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(6) is younger than you (unless he or she is permanently and totally disabled); and

(7) does not file a joint tax return with his or her spouse.

(c) An individual who:

(1) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(2) has received more than one-half of his/her support from you during the relevant year;

(3) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (b) above with respect to any person); and

(4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

Note: The definition "tax dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return and is different than the definition of "qualifying individual" that applies under the Dependent Care Expense Reimbursement Plan. Special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

1.16 How are claims determined?

Note: This claims determination procedure only covers issues related to the Plan (e.g., the ability to pay for benefits on a pre-tax basis), and claims for benefits under the "Reimbursement" Plans listed in Section 1.3. Claims for other benefits (e.g., medical and dental) are handled through the claims determination procedures in those separate plans.

Claim Submission. A claim for benefits must be made in writing and submitted to the Claims Administrator.

Benefits Denials. The Claims Administrator will decide your claim within a reasonable time not longer than thirty (30) days after it is received. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claims Administrator. You will receive written notice of any extension, indicating the reasons for the extension and the date by which a decision is expected to be made. If your claim is incomplete, and the Claims Administrator notifies you of that fact, the time period for deciding your claim will be suspended from the date the notice is provided through the date on which you respond or by which you are supposed to respond. You will be given at least forty-five (45) days in which to respond. The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If the Claims Administrator denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

(a) the specific reason or reasons for the denial;

(b) reference to the specific Plan provision on which the denial is based;

(c) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, and your right to review (on request and at no charge) relevant documents and other information.

Appealing a Denial. If your claim is denied in whole or in part, you may appeal to the Plan Administrator for a review of the denied claim. Your appeal must be made in writing within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination, or else you may also have lost your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Decision upon Appeal. The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(a) the specific reason(s) for the denial;

(b) the specific Plan provision(s) on which the decision is based;

(c) a statement of your right to review (on request and at no charge) relevant documents and other information; and

(d) if the Plan Administrator relied on "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

Note: The Claims Administrator for any insured or insurance-like option is the insurance carrier or other third party provider. The Claims Administrator for the Dexter Community Schools Flexible Benefits Plan (including the "Reimbursement" Plans listed in Section 1.3) is Next Generation Enrollment, Inc..

1.17 Who has authority to interpret the Plan?

To the fullest extent permitted under applicable law, the Plan Administrator and any other Plan fiduciary acting in its fiduciary capacity shall have the authority and discretion to interpret and apply Plan terms.

PART II.
GROUP MEDICAL BENEFITS

An important feature of the Plan is the opportunity it provides you to pay your share of the cost of coverage under the Group Medical Plan on a pre-tax basis. The medical coverage is provided through your Employer. Your share of the cost for that coverage is paid with the allocation of pre-tax dollars through salary reduction under this portion of the Plan.

2.1 What benefits are provided?

The Group Medical Plan is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers or health maintenance organizations ("HMOs"). The Group Medical Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. Those descriptive materials are incorporated into this summary by reference. If you have not been provided this information, you should contact the Plan Administrator. The Group Medical Plan is provided in accordance with the applicable contract or policy issued by the carrier.

The group medical coverage provided through the Employer is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2.2 How do I become a Participant in this portion of the Plan?

To participate in this portion of the Plan, you must first enroll in the Group Medical Plan. You may select coverage under the Group Medical Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Medical Plan. Please refer to the contract or policy governing the Group Medical Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Medical Plan, then you may participate in this portion of the Plan if you satisfy the general eligibility requirements for the Plan described in Section 1.4. If you satisfy those requirements, you will automatically become a Participant in this portion of the Plan for purposes of paying your share of the cost of Group Medical Plan coverage unless you elect not to do so.

2.3 How is the cost of group medical coverage paid?

If you participate in this portion of the Plan, the cost of group medical coverage is paid with pre-tax dollars through salary reduction. Your Employer will forward the salary reduction dollars and Employer Contribution (if any) to the provider to pay for this group medical coverage.

Note: You must be a Participant in the Plan for your portion of the premiums to be paid pre-tax.

You may elect Group Medical Plan coverage for just yourself or you may elect coverage for yourself and your spouse and/or dependents who are eligible for coverage under the terms of the Group Medical Plan. Please refer to the contract or policy governing the Group Medical Plan for information regarding who is eligible for coverage under that plan.

Note: The individuals who are eligible for coverage under the Group Medical Plan are not necessarily "dependents" under the Internal Revenue Code (for the purpose of medical benefits).

If you elect coverage for an individual who does not also meet the definition of "tax dependent" under the Internal Revenue Code (for the purpose of health benefits) described below, the fair market value of such individual's coverage will be handled as described in Section 1.15.

2.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Medical Plan, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Medical Plan, your participation in this portion of the Plan will cease as well, subject to the change in election rules described in Section 1.7.

If you cease to be eligible to participate in this Plan, your ability to pay for coverage under the Group Medical Plan on a pre-tax basis through this portion of the Plan stops.

2.5 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the Group Medical Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation rights are described later in this summary.

2.6 What if I am subject to a medical child support order?

The Group Medical Plan recognizes child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If a child is enrolled in the Group Medical Plan pursuant to a child support order, you will be able to pay the cost of that coverage through this portion of the Plan, provided you are eligible to participate as described in Section 2.2.

PART III.
GROUP DENTAL BENEFITS

An important feature of the Plan is the opportunity it provides you to pay your share of the cost of coverage under the Group Dental Plan on a pre-tax basis. The dental coverage is provided through your Employer. Your share of the cost for that coverage is paid with the allocation of pre-tax dollars through salary reduction under this portion of the Plan.

3.1 What benefits are provided?

The Group Dental Plan is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers or health maintenance organizations ("DMOs"). The Group Dental Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company or DMO) or by your Employer. Those descriptive materials are incorporated into this summary by reference. If you have not been provided this information, you should contact the Plan Administrator. The Group Dental Plan is provided in accordance with the applicable contract or policy issued by the carrier.

The group dental coverage provided through the Employer is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3.2 How do I become a Participant in this portion of the Plan?

To participate in this portion of the Plan, you must first enroll in the Group Dental Plan. You may select coverage under the Group Dental Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Dental Plan. Please refer to the contract or policy governing the Group Dental Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Dental Plan, then you may participate in this portion of the Plan if you satisfy the general eligibility requirements for the Plan described in Section 1.4. If you satisfy those requirements, you will automatically become a Participant in this portion of the Plan for purposes of paying your share of the cost of Group Dental Plan coverage unless you elect not to do so.

3.3 How is the cost of group dental coverage paid?

If you participate in this portion of the Plan the cost of group dental coverage is paid with pre-tax dollars through salary reduction. Your Employer will forward the salary reduction dollars (if any) to the provider to pay for this group dental coverage.

Note: You must be a Participant in the Plan for your portion of the premiums to be paid pre-tax.

You may elect Group Dental Plan coverage for just yourself or you may elect coverage for yourself and your spouse and/or dependents who are eligible for coverage under the terms of the Group Dental Plan. Please refer to the contract or policy governing the Group Dental Plan for information regarding who is eligible for coverage under that plan.

Note: The individuals who are eligible for coverage under the Group Dental Plan are not necessarily "dependents" under the Internal Revenue Code (for the purpose of dental benefits).

If you elect coverage for an individual who does not also meet the definition of "tax dependent" under the Internal Revenue Code (for the purpose of health benefits) described below, the fair market value of such individual's coverage will be handled as described in Section 1.15.

3.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Dental Plan, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Dental Plan, your participation in this portion of the Plan will cease as well, subject to the change in election rules described in Section 1.7.

If you cease to be eligible to participate in this Plan, your ability to pay for coverage under the Group Dental Plan on a pre-tax basis through this portion of the Plan stops.

3.5 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the Group Dental Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation rights are described later in this summary.

3.6 What if I am subject to a medical child support order?

The Group Dental Plan recognizes child support orders regarding the provision of dental coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If a child is enrolled in the Group Dental Plan pursuant to a child support order, you will be able to pay the cost of that coverage through this portion of the Plan, provided you are eligible to participate as described in Section 3.2.

PART IV.
GROUP VISION BENEFITS

An important feature of the Plan is the opportunity it provides you to pay your share of the cost of coverage under the Group Vision Benefits on a pre-tax basis. The vision coverage is provided through your Employer. Your share of the cost for that coverage is paid with the allocation of pre-tax dollars through salary reduction under this portion of the Plan.

4.1 What benefits are provided?

The Group Vision Plan is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers. The Group Vision Plan is described in separate materials which have been provided to you either directly by the carrier (the insurance company) or by your Employer. Those descriptive materials are incorporated into this summary by reference. If you have not been provided this information, you should contact the Plan Administrator. The Group Vision Plan is provided in accordance with the applicable contract or policy issued by the carrier.

The group vision coverage provided through the Employer is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

4.2 How do I become a Participant in this portion of the Plan?

To participate in this portion of the Plan, you must first enroll in the Group Vision Plan. You may select coverage under the Group Vision Plan for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Vision Plan. Please refer to the contract or policy governing the Group Vision Plan for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Vision Plan, then you may participate in this portion of the Plan if you satisfy the general eligibility requirements for the Plan described in Section 1.4. If you satisfy those requirements, you will automatically become a Participant in this portion of the Plan for purposes of paying your share of the cost of Group Vision Plan coverage unless you elect not to do s.

4.3 How is the cost of group vision coverage paid?

If you participate in this portion of the Plan the cost of group vision coverage is paid with pre-tax dollars through salary reduction. Your Employer will forward the salary reduction dollars (if any) to the provider to pay for this group vision coverage.

Note: You must be a Participant in the Plan for your portion of the premiums to be paid pre-tax.

You may elect Group Vision Plan coverage for just yourself or you may elect coverage for yourself and your spouse and/or dependents who are eligible for coverage under the terms of the Group Vision Plan. Please refer to the contract or policy governing the Group Vision Plan for information regarding who is eligible for coverage under that plan.

Note: The individuals who are eligible for coverage under the Group Vision Plan are not necessarily "dependents" under the Internal Revenue Code (for the purpose of vision benefits).

If you elect coverage for an individual who does not also meet the definition of "tax dependent" under the Internal Revenue Code (for the purpose of health benefits) described below, the fair market value of such individual's coverage will be handled as described in Section 1.15.

4.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Vision Plan, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Vision Plan, your participation in this portion of the Plan will cease as well, subject to the change in election rules described in Section 1.7.

If you cease to be eligible to participate in this Plan, your ability to pay for coverage under the Group Vision Plan on a pre-tax basis through this portion of the Plan stops.

4.5 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the Group Vision Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation rights are described later in this summary.

4.6 What if I am subject to a medical child support order?

The Group Vision Plan recognizes child support orders regarding the provision of dental coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If a child is enrolled in the Group Vision Plan pursuant to a child support order, you will be able to pay the cost of that coverage through this portion of the Plan, provided you are eligible to participate as described in Section 4.2.

PART V.
DEPENDENT CARE EXPENSE REIMBURSEMENT PLAN

Your Employer's Plan permits you to elect to receive reimbursement for some or all of your work-related dependent care expenses under the Dependent Care Expense Reimbursement Plan ("DC Plan"). Under the DC Plan, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for dependent care expenses.

5.1 How do I become a Participant?

If you satisfy the eligibility requirements of the Plan, you also satisfy the eligibility requirements for the DC Plan. You become a Participant in the DC Plan by electing benefits during your initial or subsequent annual enrollment periods.

5.2 What is my dependent care account?

If you elect benefits under the DC Plan, a dependent care account ("DC Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to pay with your salary reduction. Each payroll period, an amount equal to your salary reduction for that payroll period will be credited to your DC Account.

For example, suppose you elected to be reimbursed for $2,600 per year for eligible dependent care expenses. If you are paid every two weeks, you would have a total of $100 credited to your DC Account each payday to pay benefits under the DC Plan.

The amount that is available in your DC Account at any particular time will be whatever has been credited to such DC Account less any reimbursements.

The DC Account is a bookkeeping account only. The Employer pays benefits under the DC Plan from its general assets. There is no trust.

5.3 What are the maximum benefits I may receive?

The maximum benefits you may receive in a tax year is $5,000 if you:

(a) are married and file a joint return;

(b) are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the DC Plan, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or

(c) are single, or a head of household for tax purposes.

Note: ***The maximum is a combined maximum***. If your spouse has a dependent care program available through his or her employer, the combined total under that program and this DC Plan is the maximum described above per tax year. ***It is your responsibility to monitor your combined maximum.***

This maximum is reduced if any of the following situations exist:

(a) if you are married, reside together with your spouse, but file separate tax returns, the maximum is reduced to $2,500; or

(b) if you or your spouse have earned income less than $5,000 per tax year, the maximum is reduced to the lesser of your earned income or your spouse's earned income.

Note: If your spouse is a student or is incapable of caring for himself or herself, in general, you spouse will be deemed to have earned income of not less than $250 per month if you have one Qualifying Individual or $500 per month you have two or more Qualifying Individuals.

5.4 Who is a "qualifying individual" for whom I can claim a reimbursement?

Note: The rules are not the same as the tax deduction or exemption rules. It is your responsibility to determine whether you can request reimbursement for expenses incurred with respect to a particular individual. As discussed below, special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

General Rule. Subject to the two special rules described below, you may be reimbursed for Eligible Expenses incurred on behalf of any "qualifying individual" who is either:

(a) your "child" who: (1) is under age thirteen (13); (2) has the same principal place of abode as you for at least one-half of the year; (3) does not provide over half of his/her own support during the year; and (4) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(b) your "child" who: (1) is mentally or physically unable to care for himself or herself, (2) has the same principal place of abode as you for at least one-half of the year, (3) does not provide over half of his/her own support during the year, (4) has not attained age nineteen (19) during the year (age twenty-four (24) if a full-time student) or is permanently and totally disabled, (5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico, (6) is younger than you (unless he/she is permanently and totally disabled), and (7) does not file a joint tax return with his or her spouse;

(c) your "child" who: (1) is mentally or physically unable to care for himself or herself; (2) has the same principal place of abode as you for at least one-half of the year; (3)i has received more than one-half of his/her support from you during the relevant year; (4) who is not any person's "qualifying child" (as that term is defined under Section 152 of the Internal Revenue Code); and (5) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(d) your "relative" who: (1) is mentally or physically unable to care for himself or herself; (2) has the same principal place of abode as you for at least one-half of the year; (3) has received more than one-half of his/her support from you during the relevant year; (4) who is not any person's "qualifying child" (as that term is defined under Section 152 of the Internal Revenue Code); and (v) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico; or

(e) your spouse, if your spouse is physically or mentally incapacitated and has the same principal place of abode as you for at least one-half of the year.

"***Child***" generally includes your son, daughter, stepson, stepdaughter, eligible foster child, brother, sister, stepbrother, stepsister, or a descendant of any such person.

"***Relative***" generally includes parent (or a parent's ancestor), stepparent, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or an individual who (although not related to you) has the same principal place of abode as you and is a member of your household.

"***Spouse***" means an individual to whom you are legally married in accordance with applicable state law.

5.5 What if two people claim a child as a Qualifying Individual?

With the exception of two parents that file income taxes jointly, only one person is entitled to treat the child as a Qualifying Individual. Where multiple people are involved, there are two special rules to determine which person is entitled to treat the child as a Qualifying Individual.

(a) **Divorced or Separated Parents, or Parents Living Apart.**

Important Note: Only one person is entitled to treat the child as a Qualified Individual for purposes of the DC Plan.

If a child's parents are divorced, legally separated, separated pursuant to a written agreement, or live apart at all times during the last six (6) months of the calendar year, a special rule applies if: (1) the child is under age 13 or is mentally or physically unable to care for himself or herself; (2) the child receives more than 50% of his or her support from the parents (in aggregate); and (3) the child resides with the parents (in aggregate) for more than 50% of the year. In such situations, the child is the Qualifying Individual of the custodial parent even if the custodial parent has released the right to claim the child as a dependent. The custodial parent is generally the parent with whom the child resides for the greater number of nights during the calendar year or, if the child resides with both parents for an equal number of nights, the parent with the higher adjusted gross income for the year.

(b) **Other Situations**. If the special rule described above regarding divorce, etc. does not apply, other special tie-breaker rules of may apply. If an individual is a Qualifying Individual (under paragraphs (a) or (b) of the definition provided above) with respect to more than one person, then:

(1) if both persons are the individual's parents and they file separate federal income tax returns, then the child is the Qualifying Individual of the parent with whom the child resides for the longest period of time during the calendar year (or, if child resides with both parents for the same amount of time during the year, the parent with the highest adjusted gross income for the year). However, if that parent (i.e., the custodial parent or the parent with the highest adjusted gross income) does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other parent (i.e., the non-custodial parent or the parent with the lowest adjusted gross income). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the DC Plan***.

(2) if one person is the individual's parent and the other is not, the child is the Qualifying Individual of the parent. However, if the parent does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the earned income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child

is the Qualifying Individual of the other person (i.e., the non-parent). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the DC Plan.***

(3) if neither person is the individual's parent, the child is the Qualifying Individual of the person with the highest adjusted gross income for the year in question. However, if that person does not claim the child as a qualifying child (as defined in Section 152 of the Internal Revenue Code) for any purpose (i.e., a dependent care expense reimbursement program, the Earned Income credit, the dependency deduction, the child tax credit, and the dependent care credit), then the child is the Qualifying Individual of the other person (i.e., the person with the lowest adjusted gross income). ***This is the one person that is entitled to treat the child as a Qualifying Individual for purposes of the DC Plan***.

Important: If you enroll for dependent care benefits, it will be assumed that you are ***the one person*** entitled to treat the child as a Qualifying Individual for purposes of reimbursement under the DC Plan.

5.6 What is an "Eligible Expense"?

(a) **General Rule—Covered**. An "Eligible Expense" generally means expenses for the care of a Qualifying Individual incurred by you (or your spouse) to enable you (and your spouse) to be gainfully employed. Eligible Expenses generally include:

(1) Day care expenses;

(2) Cost of nursery school, preschool, or similar programs below the level of kindergarten;

(3) Cost of after-school care (including care for Qualifying Individuals in kindergarten and beyond);

(4) Cost of day camp, including specialty day camp;

(5) Cost of transportation provided by a care provider;

(6) Meals incidental to and inseparable from care;

(7) Employment taxes paid on behalf of a care provider;

(8) Cost of room and board provided to a care provider; or

(9) Certain indirect expenses, such as application and agency fees, if they must be paid to obtain the care.

(b) **General Rule—Not Covered**. Expenses incurred that do not enable you to be gainfully employed are generally not "eligible" including, but not limited to, expenses incurred while on vacation, sick leave, or any other type of situation where you (and your spouse) are not at work or actively looking for work (i.e., gainfully employed). Your spouse, if any, is deemed to be gainfully employed if he/she is: (1) a full time student, or (2) mentally or physically incapable of self-care and resides with you for more than one-half of the calendar year.

(c) **Daily Allocation.** Usually, expenses must be allocated on a daily basis so that expenses incurred on a day you (or your spouse) were not at work may not be reimbursed.

Special Rule. If you pay for care on at least a weekly basis, without deduction for days on which care is not provided, you are not required to allocate expenses for short, temporary absences from work, such as vacations and sick days. You are also not required to allocate expenses on a daily basis if you (or your spouse) work on a part-time basis and you pay for care on at least a weekly basis without deduction for days on which care is not provided.

(d) **Who and Where Rules**. Expenses that would otherwise be "Eligible Expenses" cannot be reimbursed if they are paid to: (1) an individual who is your child under the age of nineteen (19) at the end of the calendar year; (2) an individual who is your (or your spouse's) tax dependent; (3) an individual who was your spouse at any time during the calendar year; or (4) a parent of a Qualifying Individual who is your child under age thirteen (13).

Expenses that would otherwise be "Eligible Expenses" for services provided outside of your home may be reimbursed only if the care is for a Qualifying Individual who is: (1) your (or your spouse's) "child" under the age of thirteen (13); or (2) is another Qualifying Individual who regularly spends at least eight (8) hours per day in your home.

5.7 How do I receive my benefits under the DC Plan?

When you incur an expense that is eligible for payment, you make a claim by submitting a paper claim.

You cannot be reimbursed for any expenses above your ***available*** DC Account balance. If your claim was for an amount that was more than your current DC Account balance, the excess part of the claim will be carried over into following months, to be paid as your balance becomes adequate. You also cannot be reimbursed for any expenses that arise before the Effective Date of the DC Plan, for any expenses that arise before you become a Participant in the DC Plan, or for any expenses incurred after the close of the Plan Year.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

Claims Run-out Period: You may submit claims for Eligible Expenses incurred during the Plan Year for a period of ninety (90) days following the end of that Plan Year.

Paper Claims. When you incur an expense that is eligible for reimbursement, you may submit a claim to the Claims Administrator on an administrative form that will be supplied to you. The form will typically set forth:

(a) the amount, date and nature of the expense;

(b) the name of the person or entity to which the expense was paid;

(c) your statement that the expense has not been reimbursed, and you will not seek reimbursement for the expense, from any other source; and

(d) such other information as the Claims Administrator may require. You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

"**Claims Administrator**" means Next Generation Enrollment, Inc.

FAX: You may fax claims to 888-267-0839. Note, for the quickest processing time, complete, sign and fax your reimbursement form and all necessary documentation. A cover page is not required. Claims will be processed within two business days of receipt.
MAIL: If you prefer to mail your form and receipts, please send to PO Box 527, Ada, MI 49301.

Please keep all receipts and original documentation as required by the IRS.

If there are enough dollars credited to your DC Account, you will be reimbursed for your Eligible Expenses weekly according to the schedule established by the Plan Administrator. Reimbursements are paid by direct deposit.

5.8 Will I be taxed on the DC Plan benefits I receive?

You will not normally be taxed on benefits under the DC Plan. However to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with a list of names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement.

5.9 If I participate in the DC Plan, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may choose to participate in the DC Plan and receive credit on your federal income tax return too. However, the tax credit and the DC Account cannot be used for the same expenses. In addition, the amount of the household and dependent care credit is reduced dollar for dollar by the amount you put into your DC Account.

In certain cases, it may be more beneficial for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through the DC Account. You may want to consult your tax advisor regarding the best options under the applicable rules.

5.10 What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual eligible dependent care expenses as a credit against your federal income tax. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one dependent, or $6,000 for two or more dependents.

Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 for two or more dependents) to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents.) The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

5.11 What if I receive benefits in error?

If a reimbursement is made by the DC Plan in excess of the amount to which you are entitled under the DC Plan, the DC Plan has the right to recover such overpayment. Repayment of an overpayment is a condition of participation in the Plan.

5.12 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the DC Plan, you may not make any further contributions to your DC Account. However, you may continue to submit claims for Eligible

Expenses for an eligible dependent (as described in Sections 5.4 and 5.5) incurred while you were a Participant until the earlier of: (a) the date your DC Account reaches zero, or (b) thirty (30) days after the date you cease to be eligible to participate.

5.13 What if the dependent care expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any amounts remaining in your DC Account after payment of all Eligible Expenses shall be forfeited at the end of the Plan Year following the claims run-out period described in Section 5.7. You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual dependent care expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

5.14 What reporting will I receive?

The amounts reimbursed under this DC Plan for each calendar year will be reported on your W-2. If the actual amount paid is not known by the deadline for providing the W-2 (e.g., because of the claims run-out period), the Employer may report a reasonable estimate of the reimbursements that will be paid under the DC Plan for the year. A reasonable estimate may be the amount of benefits you elected under the DC Plan for the year.

PART VI.
MEDICAL EXPENSE REIMBURSEMENT PLAN

Your Employer's Plan permits you to elect to receive reimbursement for some or all of your uninsured medical and dental expenses under the Medical Expense Reimbursement Plan ("ME Plan"). Under the ME Plan, you provide a source of pre-tax dollars by entering into a salary reduction agreement with your Employer. Those pre-tax dollars will be used to reimburse you for your Eligible Expenses. You save Social Security and income taxes on the amount of your salary reduction for medical expenses. The coverage provided through the ME Plan is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The ME Plan is intended to be an excepted benefit under the HIPAA portability rules. Accordingly, neither the HIPAA portability rules nor the mandates of the Patient Protection and Affordable Care Act, as amended, including the preventive care mandate, apply to the ME Plan.

6.1 How do I become a Participant?

If you satisfy the eligibility requirements of the Plan you also satisfy the eligibility requirements for the ME Plan. You become a Participant in the ME Plan by electing benefits during your initial or subsequent annual enrollment periods.

Note: Participation in this ME Plan will make you ineligible to participate in the HSA Contribution Feature, and will make you and any of your dependents covered by the ME Plan ineligible to make or receive contributions to a health savings account.

6.2 What is my medical expense account?

If you elect benefits under the ME Plan, a medical expense account ("ME Account") will be established in your name to keep a record of the benefits to which you are entitled. When you complete the election form, you specify the amount of benefits you wish to pay with your salary reduction. The full amount of your election under the ME Plan will be available at any time during the Plan Year, reduced by the amount of prior reimbursements under the ME Plan received during the Plan Year.

The ME Account is a bookkeeping account only. Benefits under the ME Plan are paid from the Employer's general assets. There is no trust.

6.3 What are the maximum benefits I may receive?

The maximum annual amount of benefits you may receive under the ME Plan is $2,550 per Plan Year.

6.4 What if I am no longer eligible?

If your employment terminates or you otherwise cease to be eligible for coverage under the ME Plan, you may not make any further contributions to your ME Account, and you will not receive any further reimbursements. You may, however, continue to submit claims for expenses incurred before you terminated or otherwise ceased to be eligible for coverage until the earlier of: (a) the date your ME Account reaches zero, or (b) 30 days after the date you cease to be eligible to participate.

6.5 Can coverage be continued?

If your employment terminates or you otherwise cease to be eligible for the ME Plan, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation rights are described later in this summary.

6.6 What is an "Eligible Expense"?

(a) **Generally**. An "Eligible Expense," in most situations, means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return and for which you have not otherwise been reimbursed from health coverage, or some other source. Eligible Expenses include expenses incurred by you and your "spouse" and "dependents."

For purposes of this ME Plan, **"spouse"** means a person to whom you are legally married in accordance with applicable state law.

For purposes of this ME Plan, **"dependent"** generally includes an individual who satisfies the requirements of paragraph (1), (2), or (3) below:

(1) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(ii) will not attain age 27 during the relevant calendar year.

(2) An individual who:

(i) is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(ii) has the same principal place of abode as you for at least one-half of the relevant year;

(iii) will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(iv) did not provide over half of his/her own support during the relevant year;

(v) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico;

(vi) is younger than you (unless he/she is permanently and totally disabled); and

(vii) does not file a joint tax return with his or her spouse.

(3) An individual who:

(i) is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household;

(ii) has received more than one-half of his/her support from you during the relevant year;

(iii) is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (2) above with respect to any person); and

(iv) is a citizen, national, or resident of the United States, or a resident of Canada or Mexico.

Note: The definition "dependent" is different than the definition applicable under the Internal Revenue Code for purposes of identifying who you may claim as an exemption on your federal income tax return. Furthermore, an individual eligible for dependent coverage under the Group Medical Plan is not necessarily a "dependent" for purposes of the ME Plan. Special rules apply in some cases. For additional information, please contact the Plan Administrator or your tax advisor.

(b) **Special rules for over-the-counter items.** Eligible Expense also ***includes*** certain over-the-counter items that constitute medical care (under Section 213(d) of the Internal Revenue Code) even though a tax deduction is not available. Over-the-counter drugs and medicines (other than insulin) require a prescription to be an Eligible Expense. For this purpose, a "prescription" means a written or electronic order for a medicine or drug (1) that meets the legal requirements of a prescription in the state in which the medical expense is incurred; and (2) that is issued by an individual who is legally authorized to issue a prescription in that state.

(c) **Exceptions**. Despite the general rule stated above, Eligible Expense ***does not*** include premiums for qualified long term care coverage or premiums for any group or individual health plan.

Important: Please review Exhibit A—Eligible Medical Care Expenses to help determine what is an Eligible Expense. You are also encouraged to consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an Eligible Expense.

Caution: Publication 502 addresses medical care expenses a person may deduct on his or her income taxes. Many, ***but not all***, expenses that are tax deductible are also reimbursable under the ME Plan.

6.7 How do I receive my benefits under the ME Plan?

When you incur an expense that is eligible for reimbursement, you may submit a claim to the Claims Administrator on an administrative form that will be supplied to you. The form will typically require:

(a) the amount, date and nature of the expense,

(b) the name of the person or entity to which the expense was paid,

(c) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and

(d) such other information as the Claims Administrator may require, such as copies of bills or receipts from the providers to support your claim. With respect to claims for over-the-counter drugs and medicines (other than insulin), you must submit either: (i) a copy of the prescription or (ii) a receipt identifying the purchaser (or patient), the date and amount of the purchase, and the Rx number.

You may also be required to submit copies of bills or receipts from the provider(s) to support your claim.

"**Claims Administrator**" means Next Generation Enrollment, Inc.

FAX: You may fax claims to 888-267-0839. Note, for the quickest processing time, complete, sign and fax your reimbursement form and all necessary documentation. A cover page is not required. Claims will be processed within two business days of receipt.
MAIL: If you prefer to mail your form and receipts, please send to PO Box 527, Ada, MI 49301.

Please keep all receipts and original documentation as required by the IRS.

You will be reimbursed for your Eligible Expenses according to the schedule established by the Plan Administrator. Reimbursements are paid by direct deposit.

You cannot be reimbursed for any expenses above the amount of your election. You also cannot be reimbursed for any expenses that arise before the Effective Date of the ME Plan, for any expenses that arise before you become a Participant in the ME Plan, or for any expenses incurred after you terminate employment or otherwise cease to be eligible for coverage under the ME Plan, unless coverage is continued.

Please note that it is not necessary that you have actually paid an amount for that expense to be eligible for reimbursement. You only must have incurred the expense and not have been reimbursed or paid from another source. An expense is "incurred" when the service which gives rise to the expense has been provided, not when you are billed or when you pay the expense.

Claims Run-out Period: You may submit claims for Eligible Expenses incurred during the Plan Year for a period of ninety (90) days following the end of that Plan Year.

6.8 Can I carryover my ME Account to the next Plan Year?

No. Any amounts remaining in your ME Account attributable to a particular Plan Year shall be forfeited following the claims run-out period described above. You will not be entitled to carryover or receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred, on the one hand, and the annual benefit you have elected and paid for, on the other. ***If you do not use it, you lose it.***

6.9 What if I receive benefits in error?

If a payment for benefits is made by the ME Plan in excess of the benefit to which you are entitled under the ME Plan, the ME Plan has the right to recover such overpayment from the payee. Repayment of an overpayment is a condition of participation in the Plan.

6.10 What if I am subject to a medical child support order?

Notwithstanding any provision in the ME Plan to the contrary, the ME Plan shall recognize child support orders regarding the provision of medical coverage for a child, including orders under the Child Support Performance and Incentive Act of 1998 to the extent required by law. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator.

PART VII.
HSA CONTRIBUTION FEATURE

7.1 What benefits are provided?

An important feature of the Plan is the opportunity it provides you to make contributions to a health savings account ("HSA") on a pre-tax basis through the HSA Contribution Feature.

7.2 How do I become a Participant?

In addition to satisfying the eligibility requirements for the Plan, you must meet certain other requirements in order to participate in the HSA Contribution Feature. To be eligible, you must:

(a) be covered by the Employer's Qualifying High Deductible Health Plan;

(b) not be claimed as another person's tax dependent;

(c) not be actually covered by Medicare; and

(d) not have any health coverage other than coverage under a Qualifying High Deductible Health Plan, except "Permitted Insurance" or "Permitted Coverage," whether or not such coverage is sponsored by your Employer. Other coverage that will disqualify you from being eligible for the HSA Contribution Feature includes, but is not limited to, coverage under your spouse's health plan, coverage under the ME Plan, coverage under your spouse's medical expense reimbursement plan, and coverage under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

If you are eligible to participate, you become a Participant in this HSA Contribution Feature by electing benefits during your initial or subsequent annual Enrollment Periods and, if required, by providing a special form to your Employer – the "Certification of HSA Eligibility" form – in which you certify that you are eligible to participate.

7.3 What is a Qualifying High Deductible Health Plan?

A "Qualifying High Deductible Health Plan" generally is a health plan providing coverage that meets one of the following requirements:

(a) self-only coverage with a deductible of at least $1,300 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care) and with an annual out-of-pocket limit of not more than $6,450 (as indexed for inflation); or

(b) family coverage with a deductible of at least $2,600 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care), without an embedded individual deductible less than $2,600, and with an annual out-of-pocket limit of not more than $12,900 (as indexed for inflation).

Note: A health plan that covers prescription drugs prior to the specified deductible is not a Qualifying High Deductible Health Plan.

7.4 What is Permitted Insurance and Permitted Coverage?

"Permitted Insurance" is:

(a) insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, or similar liabilities as specified by the IRS;

(b) insurance for specified disease or illness (e.g., cancer insurance); or

(c) insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance).

"Permitted Coverage" is coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted coverage includes some medical reimbursement accounts and health reimbursement arrangements (HRAs), such as limited scope medical reimbursement accounts and HRAs (i.e., the Limited Scope ME Plan provided through this Plan), HRAs for which the payment or reimbursement of medical expenses (except expenses for preventive care, dental care, vision care, or long-term care premiums) is suspended, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs. It also includes wellness programs and employee assistance programs that do not provide significant benefits in the nature of non-preventive medical care or treatment.

7.5 What other coverage disqualifies me?

You are not eligible to make or receive contributions to an HSA if you have any coverage that is not coverage under a Qualifying High Deductible Health Plan, coverage under Permitted Insurance, or Permitted Coverage. Other coverage that will disqualify you from being eligible for the HSA Contribution Feature includes, but is not limited to, coverage under your spouse's health plan (that is not a Qualifying High Deductible Health Plan), coverage under the ME Plan, coverage under your spouse's medical expense reimbursement plan, and coverage under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

7.6 What is my HSA?

Your HSA is a health savings account (as defined under the Internal Revenue Code) established by you with a third party trustee/custodian (e.g., bank or insurance company) selected by your Employer that is authorized to be the trustee of HSAs. Your Employer does not establish or sponsor your HSA. Furthermore, your Employer does not own your HSA; it is owned by you.

You may invest the funds in your HSA as allowed by the trustee/custodian of the account. Your Employer has no control of or responsibility for the investment of your HSA.

7.7 What are the limits on the amount of contributions?

The total contributions made by you and/or made on your behalf (i.e., contributions by your Employer) into HSAs owned by you are subject to a maximum contribution limit. Generally, the maximum contribution you may receive in a year is an indexed amount as follows: $3,350 if you have self-only coverage or $6,650 if you have family coverage (for 2015).

You are allowed to make or receive an additional "catch-up" contribution for the year in which you will attain age 55 before the end of the year and for any year thereafter while you remain eligible. The catch-up contribution is currently $1,000 per year.

If you are eligible for contributions for only a portion of the year, your maximum contribution (including catch up contributions) is determined in accordance with the following rules:

(a) **Not Eligible on December 1st.** If you cease to be eligible for contributions prior to December 1st of a particular year, the contribution limit for that year will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible.

> **For example**, if you have single coverage under a Qualifying High Deductible Health Plan, are not eligible for catch up contributions, but are eligible only during January through June (i.e., six months of the year), your maximum contribution limit is 50% of the annual maximum.

(b) **Eligible on December 1st.** If you become eligible for HSA contributions during a particular year and you are eligible as of December 1st of that year, your maximum contribution for that year is the full indexed amount. However, if you become ineligible for HSA contributions during the twelve (12) month period beginning with December of that year, you will not be entitled to the full maximum contribution. Instead, your maximum contribution will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible during that year. The excess contributions will be included in your gross income and a 10% additional tax will be imposed on those contributions.

If both you and your spouse have health savings accounts, the limit is divided equally between you (unless you agree to a different allocation).

Rollover contributions may also be made to an HSA from another health savings account or from an Archer MSA. Rollover contributions are not subject to the contribution limit described above.

7.8 What happens if my contributions exceed the contribution limit?

If the contributions to your HSA exceed the applicable maximum contribution limit for a year, generally the excess contributions will be included in your income and an excise tax will be imposed upon them. You will also be taxed on any earnings earned on the excess amounts. However, you can avoid the excess tax if you take a distribution of the excess contributions (and the net income attributable to the excess contribution) before the last day (including extensions) for filing your federal income tax return.

7.9 What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

7.10 What are the rules regarding distributions from my HSA?

Your Employer has no control over or involvement with distributions made from your HSA. Your Employer does not substantiate expenses for which such distributions are made. Information regarding the procedure for obtaining distributions and the consequences of taking distributions is available from the trustee/custodian of your HSA.

7.11 When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in Plan ceases or the date you no longer satisfy the eligibility requirements described in Section 7.2. However, you need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Plan, provided you

are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Plan.

Note: This HSA Contribution Feature is ***not*** a group health plan for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Family and Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature. However, COBRA, FMLA, and USERRA may apply to the Qualifying High Deductible Health Plan.

7.12 Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in your HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

7.13 What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from the IRS.

PART VIII.
CASH BENEFIT

8.1 What benefits are provided?

The Plan permits you to receive a cash payment of the available Employer Contribution as described herein.

8.2 How do I become a Participant?

To become a Participant in this portion of the Plan, you must first become a Participant in the Plan. If you satisfy those requirements, you become a Participant in this portion of the Plan by electing to receive a cash payment during your initial or subsequent annual enrollment periods.

In addition, to receive a cash payment, you must waive coverage under the Group Medical Plan. To waive coverage under the Group Medical Plan, you must complete and submit a "waiver of coverage" form available from the Plan Administrator. If you become covered under the Group Medical Plan, you will cease to be eligible for cash payments under this portion of the Plan.

8.3 What amount of cash may I receive?

The amount of the cash payment is based upon your employment classification:

DEA (teachers) – full-time Employee:	$100 per month
DEA (teachers) – part-time Employee:	$50 per month
DAA (Administrators):	$100 per month
All others:	$0 per month

8.4 When is the cash payment made?

The cash payment will be pro-rated and made in substantially equal installments each pay period. The payments will be incorporated into the Participant's regular paycheck. All cash payments constitute taxable income and are subject to withholding to the extent required by law.

8.5 What if I am no longer eligible?

If your employment terminates, or you otherwise cease to be eligible to participate in the Plan, the cash payments cease. Only Participants are eligible to receive a cash payment.

PART IX.
CONTINUATION COVERAGE

A Participant, and any others who are covered through that Participant, ***may*** be able to elect to continue coverage under certain Optional Benefits in accordance with COBRA, USERRA, and applicable state continuation laws.

9.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")), as it applies to the Employer through the Public Health Services Act, requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. At the end of the maximum coverage period (described below), individual conversion coverage will be offered if it is otherwise available under the Plan.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

This notice covers the following group health plan(s) sponsored by your Employer:

- Dexter Community Schools Group Medical Plan
- Dexter Community Schools Group Dental Plan
- Dexter Community Schools Group Vision Plan
- Dexter Community Schools Medical Expense Reimbursement Plan

Each person covered under the Plan(s) should read this notice carefully.

Qualifying Events. Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary."

Qualifying event. A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

Qualifying beneficiary. A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event was covered under the group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or place for adoption with a qualified beneficiary ***who was the employee*** is a qualified beneficiary is if he or she was covered under the group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provide coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

Employee Loss. If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

Spouse's Loss. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

(a) the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

(b) the employee's death; or

(c) divorce or legal separation from the employee.

Note: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce of legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

Dependent Child's Loss. If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

(a) the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

(b) the employee's death;

(c) divorce or legal separation of the employee and the child's other parent; or

(d) the child ceasing to be a "dependent child" under the terms of the plan.

Employer's Bankruptcy. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

Responsibility to Notify. In certain circumstances, you are required to provide notification to the Plan in order to protect your rights under COBRA.

(a) **Notice of Qualifying Event**. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of:

(1) the date of the qualifying event;

(2) the date coverage would be lost because of the qualifying event; or

(3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

The notice must be provided in writing and be mailed to the COBRA Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;

(2) state the name and address of the employee or former employee who is or was covered under the Plan;

(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;

(4) include a detailed description of the event;

(5) identify the effective date of the event; and

(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

(b) **Notice of Second Qualifying Event**. In addition, the employee or a family member (of a representative acting on behalf of the employee or family member) must notify the Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;

(2) state the name and address of the employee or former employee who is or was covered under the Plan;

(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;

(5) include a detailed description of the event;

(6) identify the effective date of the event; and

(7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

(c) **Notice of Disability**. Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the COBRA Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of:

(1) the date of the disability determination;

(2) the date of the qualifying event;

(3) the date coverage would be lost because of the qualifying event; or

(4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.)

The notice must be provided in writing and be mailed to the COBRA Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) state the name of the Plan;

(2) state the name and address of the employee or former employee who is or was covered under the Plan;

(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;

(4) identify the nature and date of the initial qualifying event the qualified beneficiaries to COBRA coverage;

(5) state the name of the disabled qualified beneficiary;

(6) identify the date upon which the disabled qualified beneficiary became disabled;

(7) identify the date upon which the Social Security Administration made its determination of disability; and

(8) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able

to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided with thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the COBRA Administrator of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the COBRA Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

Important: Failure to provide timely notification of a qualifying event ends the right to COBRA continuation coverage.

Election Rights. When a qualifying event occurs, or when the COBRA Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the COBRA Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Plan Administrator are the same entity, the COBRA Administrator has forty-four (44) days to provide the option to elect COBRA coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends.

Note: Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

Note: Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

Duration. The law requires that qualified beneficiaries generally be allowed to maintain continuation coverage as follows:

(a) **Eighteen (18) Months**. If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date coverage would otherwise be lost because of the qualifying event.

(b) **Disability Extension**. For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's

termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

(c) **Pre-Qualifying Event Medicare Extension**. The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event, or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

(d) **Thirty-Six (36) Months**. For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date of the date coverage would otherwise be lost because of the qualifying event.

(e) **Second Qualifying Events**. If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred, the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date coverage would otherwise be lost because of the original qualifying event that triggered the continuation coverage.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

Cost. A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18^{th}) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

Premature Ending. The law provides that continuation coverage shall automatically end for any of the following reasons:

(a) the Employer no longer provides group health coverage to any of its employees;

(b) the premium for continuation coverage is not paid on time (including any applicable grace period);

(c) after electing COBRA, the qualified beneficiary becomes covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any applicable pre-existing condition that you have;

Note: Under HIPAA, an exclusion or limitation of the other group health plan might not apply at all, depending on the length of the qualified beneficiary's creditable coverage prior to enrolling in the other group health plan. If the other plan has applicable exclusions or limitations, then COBRA coverage terminates after the exclusion or limitation no longer applies (for example, after a twelve (12) month pre-existing condition waiting period expires).

(d) after electing COBRA coverage, the qualified beneficiary becomes entitled to (actually covered under) Medicare;

Notice Obligation: The employee or a family member must notify the COBRA Administrator immediately if any qualified beneficiary actually becomes covered by another group health plan or Medicare. Regardless of when such notification is provided, coverage will terminate retroactively to the date of the coverage under the other group health plan or Medicare. If, for whatever reason, a qualified beneficiary receives any medical benefits under the Plan after coverage is to cease under these rules, the Plan reserves the right to seek reimbursement from the qualified beneficiary.

(e) with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled (this cuts short the coverage for all qualified beneficiaries with extended coverage); or

Note: This cuts short the coverage for all qualified beneficiaries with extended coverage.

(f) termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

Insurability & Conversion. A qualified beneficiary does not have to demonstrate insurability to elect continuation period. At the conclusion of the available continuation coverage, there must be an opportunity to convert to individual coverage if such coverage is offered under the Plan.

Other Options. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Address Changes: Important information is distributed by mail. In order to protect your family's rights, if a qualified beneficiary's address changes, the qualified beneficiary or someone on its behalf should notify the Plan Administrator immediately.

COBRA Administrator: All questions, notices, and other communication regarding COBRA and the Plan should be directed to:

Next Generation Enrollment, Inc.
455 Pettis Avenue SE
Ada, MI 49301
Phone: 888-266-1732

For more information about your rights under COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

9.2 What rules apply to the Medical Expense Reimbursement Plan?

Modified COBRA continuation coverage rules apply to the Medical Expense Reimbursement Plan. Continuation coverage is generally available on the same terms and conditions as described above. There are, however, several differences. For example, the beginning date of the continuation coverage is earlier. If elected, continuation coverage begins on the date of the qualifying event. Furthermore, the maximum duration of the continuation coverage is much shorter. If the account is "underspent" at the time of the loss, the maximum duration of COBRA is through the end of the Plan Year in which the loss takes place. If the account is "overspent" at the time of the loss, there is no requirement that COBRA be offered.

Underspent. An account is UNDERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is greater than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

Overspent. An account is OVERSPENT when the remaining annual limit (elected annual limit minus expenses reimbursed as of date of COBRA qualifying event) is less than the maximum COBRA premium (sum of monthly contributions for the rest of the plan year plus 2%) that can be charged for the rest of the plan year.

9.3 What are my continuation rights under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended, requires all employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your U-continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the USERRA Administrator.

This notice covers the following group health plan(s) sponsored by your Employer:

- Dexter Community Schools Group Medical Plan
- Dexter Community Schools Group Dental Plan
- Dexter Community Schools Group Vision Plan
- Dexter Community Schools Medical Expense Reimbursement Plan

Each person covered under the Plan(s) should read this notice carefully.

Service Leave Event. If covered by any of the group health plans described above, the employee has the right to elect U-continuation coverage for him/herself and his/her dependents if they lose coverage under such plan due to an absence from employment for service in the uniformed services (a "service leave").

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have sixty (60) days to elect U-continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if the no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Note: Your dependents with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if you elect U-continuation coverage.

Duration. The law requires that you generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or family members that are not on service leave.

Cost. A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of within which to make the payment. The length of the grace period will be thirty days (30), unless a longer period is provided in the insurance policy or plan document applicable to the Plan.

Termination of the Continue Coverage. The U-continuation coverage may be terminated for any of the following reasons:

(a) the Employer no longer provides group health coverage to any of its employees;

(b) the premium for U-continuation coverage is not paid on time (including the grace period);

(c) your failure to return from service or apply for a position of employment as required under USERRA; or

(d) termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

Insurability. You do not have to demonstrate insurability to elect U-continuation coverage.

USERRA Administrator: All questions, notices, and other communication regarding USERRA and the Plan should be directed to:

Next Generation Enrollment, Inc.
455 Pettis Avenue SE
Ada, MI 49301
Phone: 888-266-1732

PART X.
FAMILY AND MEDICAL LEAVE ACT OF 1993

10.1 Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. This Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities.

Note: You should contact your Employer regarding any FMLA questions. The Claims Administrator does not have authority to make these decisions.

PART XI.
ADMINISTRATIVE INFORMATION

Plan:

Plan Name:	Dexter Community Schools Flexible Benefit Plan
Plan Type:	Section 125 Cafeteria Plan

Employer, Plan Administrator, and Agent for Service of Legal Process:

Name:	Dexter Community Schools
Address:	7714 Ann Arbor Street
City, State Zip:	Dexter, MI 48130
Phone/Fax Number:	734-424-4107 / (734)424-4111
EIN:	38-6007821
Contact Person:	Sharon Raschke

PLAN NAME	PLAN TYPE	PLAN NUMBER
Dexter Community Schools Flexible Benefits Plan	Cafeteria Plan	N/A
Dexter Community Schools Group Medical Plan	Health and Accident	N/A [Not subject to ERISA]
Dexter Community Schools Group Dental Plan	Health and Accident	N/A [Not subject to ERISA]
Dexter Community Schools Group Vision Plan	Health and Accident	N/A [Not subject to ERISA]
Dexter Community Schools Dependent Care Expense Reimbursement Plan	Dependent Care Expense Reimbursement	N/A [Not subject to ERISA]
Dexter Community Schools Medical Expense Reimbursement Plan	Health and Accident	N/A [Not subject to ERISA]
Dexter Community Schools Health Savings Account Feature	Health Savings Account (contributions only)	N/A [Not subject to ERISA]

Claims Administrator:

Benefit/plan	Claims Administrator Address/Phone #
Dexter Community Schools "Reimbursement" Plans listed in Section 1.3	Next Generation Enrollment, Inc. PO Box 527 Ada, MI 49301 Toll-free Phone: 888-266-1732 Toll-free Fax: 888-267-0839

This Plan does not have a trust; therefore, there are no trustees.

EXHIBIT A
Eligible Medical Care Expenses

ME Plan. Medical and dental expenses that qualify as expenses for medical care under IRS rules generally qualify as Eligible Expenses for reimbursement under the Plan. Those may take the form of co-pays, deductibles, and medical expenses not covered by other insurance. Often expenses that qualify for deductions under IRS rules are Eligible Expenses, but in some instances expenses that are deductible will not be reimbursable and expenses that are not deductible will be reimbursable. Some specific examples are identified below. The following is not an exhaustive list and there are other expenses that are eligible if they satisfy the IRS rules.

Dental & Orthodontic Care

Allowable expenses:

- Dental treatment
- Artificial teeth/dentures
- Braces, orthodontic devices

Expenses specifically disallowed by the IRS or courts:

- Teeth whitening
- Toothbrushes and toothpaste, even if special type is recommended by dentist

Therapy Treatments

Allowable expenses:

- X-ray treatments
- Treatment for alcoholism or drug dependency
- Legal sterilization
- Acupuncture
- Vaccinations
- Hair transplant
- Physical therapy (as a medical treatment)
- Fee to use swimming pool for exercises prescribed by physician to alleviate specific medical condition such as rheumatoid arthritis
- Speech therapy
- Smoking cessation programs and prescribed drugs to alleviate nicotine withdrawal

Expenses specifically disallowed by the IRS or courts:

- Physical treatments unrelated to a specific health problem (e.g., massage for general well-being)
- Any illegal treatment
- Cosmetic surgery
- Treatment for baldness (unless it is for a specific medical condition and not for cosmetic purposes)
- Electrolysis (unless it is for a specific medical condition and not for cosmetic purposes)

Fees/Services

Allowable expenses:

- Physician's fees and hospital services
- Nursing services for care of a specific medical ailment
- Cost of a nurse's room and board if paid by the taxpayer where nurse's services qualify
- Social Security tax paid with respect to wages of a nurse where nurse's services qualify
- Services of chiropractors
- Christian Science practitioner fees
- Diagnostic tests

Expenses specifically disallowed by the IRS or courts:

- Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature
- Nursemaids or practical nurses who render general care for healthy infants
- Fees for exercise, athletic, or health club membership when there is no specific health reason for needing membership
- Marriage counseling provided by clergyman

Hearing Expenses

Allowable expenses:

- Hearing aids and hearing aid battery
- Hearing aid repair
- Special telephone equipment

Medicine and Drugs

Allowable expenses:

- Medicine and drugs that require a prescription
- Insulin
- Prescribed over the counter medicine and drugs when used to alleviate or treat personal injuries or sickness (including antacids, antihistamines, aspirin/pain relievers, cold medicines, acne medicine, etc.)

Expenses specifically disallowed by the IRS or courts:

- Medicine and drugs for personal, general health, or cosmetic purposes
- Dietary supplements if for general health

Medical Equipment

Allowable expenses:

- Blood Sugar test kits
- Wheelchair or autoette (cost of operating/maintaining)
- Crutches (purchased or rented)
- Special mattress & plywood boards prescribed to alleviate arthritis
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
- Artificial limbs
- Support hose (if medical necessary)
- Wigs (where necessary to mental health of individual who loses hair because of disease)
- Excess cost of orthopedic shoes over cost of ordinary shoes
- Breast pumps for nursing mothers

Expenses specifically disallowed by the IRS or courts:

- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased by an individual with dust allergy
- Mechanical exercise device not specifically prescribed by physician

Physicals

Allowable expenses:

- Physicals and other well visits
- Immunizations

Expenses specifically disallowed by the IRS or courts:

- Physicals for employment purposes

Vision Care

Allowable expenses:

- Optometrist's or ophthalmologist's fees
- Eyeglasses and prescription sunglasses
- Insurance for replacement of lost or damaged contact lenses
- Contact lens and contact lens solutions
- Laser eye surgery

Assistance for the Handicapped

Allowable expenses:

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training and maintaining)
- Household visual alert system for deaf person
- Excess costs of specifically equipping automobile for handicapped person over cost of ordinary automobile; device for lifting handicapped person into automobile
- Special devices, such as tape recorder and typewriter, for a blind person

Psychiatric Care

Allowable expenses:

- Services of psychotherapists, psychiatrists and psychologists

Expenses specifically disallowed by the IRS or courts:

- Psychoanalysis undertaken to satisfy curriculum requirements of a student

Miscellaneous Charges

Allowable expenses:

- X-rays
- Expenses of services connected with donating an organ
- Excess cost of medically prescribed diet

Expenses specifically disallowed by the IRS or courts:

- Expenses of divorce when doctor or psychiatrist recommends divorce
- Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes)
- Cost of special foods taken as a substitute for regular diet, when the special diet is not medically necessary or taxpayer cannot show cost in excess of cost of a normal diet
- Maternity clothes
- Diaper service

• The cost of a medically prescribed weight loss program • Breast reconstructive surgery following mastectomy as part of treatment for cancer • Contraceptives • Fertility treatments • Medical records charges • Bandages • Lactation supplies for nursing mothers • Cost of transportation (e.g., mileage) primarily for and essential to medical care	• Distilled water purchased to avoid drinking fluoridated county water supply • Installation of power steering in automobile • Pajamas purchased to wear in hospital • Mobile telephone used for personal calls as well as calls to physician • Union dues for sick benefits for members • Contributions to state disability funds • Auto insurance providing medical coverage for all persons injured in or by the taxpayer's automobile, where amounts allocable to taxpayer and dependent is not stated separately • Long-term care services • Funeral expenses
Insurance	
Allowable expenses: None	*Expenses specifically disallowed by the IRS or courts:* • Health insurance premiums (including individual and non-employer sponsored coverage and including continuation premiums) • Long term care insurance premiums