PINCKNEY COMMUNITY SCHOOLS

CAFETERIA PLAN

MEDICAL EXPENSE REIMBURSEMENT PLAN

AND

DEPENDENT CARE ASSISTANCE PLAN

AND

PREMIUM CONTRIBUTION BENEFIT PLAN

Revised: 10/1/2002, 11/20/2003, 09/08/2005
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9/20/2012 Effective 1/1/2013, 12/4/2014 Effective 1/1/2015

TABLE OF CONTENTS

GENERAL INFORMATION

NAME OF PLANS:	Pinckney Community Schools Cafeteria Plan Pinckney Community Schools Medical Reimbursement Plan Pinckney Community Schools Dependent Care Assistance Plan Pinckney Community Schools Premium Contribution Benefit Plan
NAME OF SPONSOR:	Pinckney Community Schools, A General Powers School District
ADDRESS OF SPONSOR:	2130 East M-36 Pinckney, MI 48169
TELEPHONE NUMBER:	(810) 225-3900
IDENTIFICAITON NUMBER:	38-6002465
PLAN NUMBERS:	511, 512 and 513, respectively
TYPES OF PLANS:	Cafeteria Plan, Medical Expense Reimbursement Plan, Dependent Care Assistance and Premium Contribution Benefit Plan
PLAN YEAR:	Begins January 1 and ends December 31
PLAN ADMINISTRATOR:	Assistant Superintendent for Finance & Operations

This one document includes three separate plans: a Cafeteria Plan, a Medical Expense Reimbursement Plan, Dependent Care Assistance and a Premium Contribution Benefit Plan.

The Plans set forth in this document are government plans and, therefore, are not subject to Titles I and IV of ERISA.

PINCKNEY COMMUNITY SCHOOLS
CAFETERIA PLAN
MEDICAL EXPENSE REIMBURSEMENT PLAN
DEPENDENT CARE ASSISTANCE PLAN
PREMIUM CONTRIBUTION BENEFIT PLAN

The Board of Education of the Pinckney Community Schools, a General Powers School District (the "Employer"), has approved the amendment and restatement of its Cafeteria Plan (previously known as its "Flexible Benefits Plan"), and has approved for future adoption the Medical Expense Reimbursement Plan, Dependent Care Assistance Plan and a Premium Contribution Plan, each as set forth in this single document. Each such plan is restated or adopted and effective as set forth below.

WHEREAS, the Employer previously adopted a Plan under §125 of the Code, named the "Pinckney Community Schools Flexible Benefits Plan", effective October 1, 1990; and Section 7.01 thereof allows the Employer the right to amend said plan at any time;

WHEREAS: the Employer wishes to amend and restate its prior plan under §125 of the Code; and approve for subsequent adoption a Medical Expense Reimbursement Plan under § 105(b) of the Code, a Dependent Care Assistance Plan under §129 of the Code and a Premium Contribution Benefit Plan; and offer its employees who satisfy the eligibility requirements set forth herein the choice to receive on or more of the Benefits described below;

NOW THEREFORE, the Employer approves the following Plans for restatement and/or adoption, to be effective as set forth below:

ARTICLE I
INTRODUCTION

1.1 **Cafeteria Plan Status**: This document is intended to constitute a written plan qualifying as a Cafeteria Plan under §125 of the Code. The purpose of this document as a Cafeteria Plan is to provide each Participant the choices described in Section 4.1 below. It is intended that the Participant's choices and the Employer's contribution will not constitute "constructive receipt" of income to the Participant.

1.2 **Medical Expense Reimbursement Plan Status**: This document is also intended to constitute a separate written plan qualifying as a Medical Expense Reimbursement Plan within the meaning of §105(b) of the code. The purpose of this document as a Medical Expense Benefit for Eligible Medical Care Expenses incurred by the Participant for himself/herself and his/her Dependents. It is also intended that the reimbursements under the Medical Expense Reimbursement Plan be eligible for exclusion from the Participant's gross income under §105(b) of the Code.

1.3 **Dependent Care Assistance Plan Status**. This document is also intended to constitute a separate written plan qualifying as a Dependent Care Assistance

Plan within the meaning of §129 of the Code. The purpose of this document as a Dependent Care Assistance Plan, when adopted and effective is to reimburse Participants who elect this Benefit for Eligible Employment Related Expenses incurred by the Participant. It is also intended that the reimbursements under the Dependent Care Assistance Plan be eligible for exclusion from the Participant's gross income under §129(a) of the Code.

1.4 **Premium Contribution Benefit Plan Status**: This document is also intended to constitute a separate written plan qualifying as a Premium Contribution Benefit Plan within the meaning of §105(b) of the code. The purpose of this document as a Premium Contribution Benefit for Eligible Premium Contribution Expenses incurred by the Participant for himself/herself and his/her Dependents. It is also intended that the reimbursements under the Premium Contribution Reimbursement Plan be eligible for exclusion from the Participant's gross income under §105(b) of the Code.

ARTICLE II
PARTICIPATION AND EFFECTIVE DATES

2.1 **Adoption and Effective Date of Plans**. The Cafeteria Plan is amended and restated pursuant to this document, effective on **January 1, 2015.** The Employer adopts the Medical Expense Reimbursement Plan Dependent Care Assistance and the Premium Contribution Benefit Plan upon the execution of this document, to be effective at such later date(s) as it determines, by delivering written notification of such Effective Date to the Plan Administrator and the eligible Employees and attaching a copy of such notice hereto.

2.2 **Eligibility**. All Employees shall be eligible to participate in the Plan(s) upon his/her date of employment with the Employer; provided, however, any Employee whose employment is subject to a collective bargaining agreement between the Employer and any collective bargaining group unit (a union), shall become eligible when so provided and acknowledged through the collective bargaining process.

2.3 **Commencement of Participation**. Each Employee shall commence participation in the Plan(s) set forth in this document on the first day of the calendar month coincident with or following the later of (1) his/her date of employment with the Employer, (ii) the effective date of commencement of such Plan, or (iii) the date specified in the collective bargaining agreement covering such employee. However, commencement of coverage and Benefits under the Medical Plan shall be as stated therein.

2.4 **Cessation of Participation**. A Participant will cease to be a Participant in each of the Plans set forth in this document as of the earlier of: (a) the date on which any such Plan terminates, or (b) the date on which he/she ceases to be an Employee; provided, however, a Participant may continue to participate in the Medical Expense Reimbursement Plan and the Dependent Care Assistance Plan, if they are effective pursuant to Section 2.1 above, until the end of the Plan Year, as specifically provided below in Sections 6.3 and 7.3, respectively.

ARTICLE III
DEFINITIONS

For purposes of the respective Plans set forth in this document, the following terms shall have the meaning set forth below:

3.1 "**Benefits**" mean the amounts paid to, or coverage received by, Participants under the Plans established hereunder, as reimbursement, compensation or coverage, whichever the Participant elects.

3.2 "**Code**" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section of the Code includes reference to any comparable or succeeding provisions of any legislation, which amends, supplements or replaces such section.

3.3 "**Dependent**", for purposes of the Medical Plan, has the same meaning as given such term under the Medical Plan. For purposes of the Medical Expense Reimbursement Plan, "Dependent" means and includes a Participant's spouse and those individuals who qualify as a "dependent" for income tax purposes under §152 of the Code. For purposes of the Dependent Care Assistance Plan, "Dependent" means and includes any individual who is (i) a "dependent" of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to a deduction under §151(c) of the Code, or (ii) a "dependent" (within the meaning of §152 of the Code) or the Spouse of the Participant who is physically or mentally incapable of caring for himself/herself. For purposes of determining whether an individual is a Dependent of the Participant under the Dependent Care Assistance Plan, the special rules of §21(e)(5) of the Code shall apply with respect to treating a child under the age of 13 as the dependent of the custodial parent in the case of divorced parents.

3.4 **"Dependent Care Assistance"**, for purposes of the Dependent Care Assistance Plan, means the payment or provision of those services which if paid for by the Participant would be considered "employment related expenses" under §21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment), and shall be determined in accordance with §129(e)(1) of the Code.

3.5 **"Disability Plan"**, means the group disability plan sponsored by the Employer for its Employees, as more particularly described in the group contract/policy issued by the insurance company.

3.6 **"Earned Income**", for purposes of the Dependent Care Assistance Plan, means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits), but such term does not include any amounts received: (i) under the Plans established hereunder or any other dependent care assistance program under §129 of the Code; (ii) as a pension or annuity; or (iii) as unemployment or worker's compensation.

3.7 **"Educational Institution"**, for purposes of the Dependent Care Assistance Plan, means any educational organization, the primary function of which is the

presentation of formal instruction, and which normally maintains a regular faculty and curriculum, and normally has a regularly enrolled body of students at the place where its educational activities are regularly carried on.

3.8 **"Effective Date"** for the amended and restated Cafeteria Plan is **January 1, 2015**. The Effective Date for commencement of the Medical Expense Reimbursement Plan and the Dependent Care Assistance Plan shall be as set forth in the written notice of same, as provided for in Section 2.1 above.

3.9 **"Eligible Employment Related Expenses",** for purposes of the Dependent Care Assistance Plan, means all Employment Related Expenses incurred by a Participant which are paid to an individual, who is not: (i) a Dependent of the Participant, or (ii) a child of the Participant under the age of 19.

3.10 **"Eligible Medical Care Expense"**, for purposes of the Medical Expense Reimbursement Plan, means any Medical Care Expense which was not allowed as a deduction to the Participant under § 213 of the Code for any prior calendar year, and which is paid to the Participant (directly or indirectly) as reimbursement for such expense incurred by the Participant for himself/herself and/or his/her Dependent.

3.11 **"Employee"** means any individual employed by the Employer, and does not include independent contractors or leased employees. However, any Employee whose employment is subject to a collective bargaining agreement between the Employer and any collective bargaining group/unit (a union) shall become eligible when so provided and acknowledged through the collective bargaining process.

3.12 **"Employment Related Expenses",** for purposes of the Dependent Care Assistance Plan, means expenses incurred for: (a) Qualifying Services rendered to a Qualifying Individual; or (b) the cost of sending (i) a Dependent of the Participant who is under the age of 13, or (ii) a Dependent or Spouse of the Participant who is incapable of caring for himself/herself and who regularly spends at least eight hours each day in the Participant's household, to a Qualifying Day Care Center, but only if such expenses are incurred to enable the Participant to be gainfully employed for any period for which there is at least one Qualifying Individual with respect to such Participant.

3.13 **"Life Insurance Plan"**, means the group life insurance plan sponsored by the Employer for its Employees, as more particularly described in the group contract/policy issued by the insurance company.

3.14 **"Medical Care Expense",** for purposes of the Medical Expense Reimbursement Plan, has the same meaning as defined in §213(d) of the Code, and includes amounts paid for the diagnosis, cure, mitigation or prevention of disease, or for the purpose of affecting any structure or function of the body; and any amounts paid for transportation primarily for, and essential to, such medical care; but does not include certain cosmetic surgery.

3.15 **"Medical Plan"** means the group medical/hospitalization, dental and vision plan sponsored by the Employer for its Employees, as more particularly described in the group contract/policy issued by the insurance company.

3.16 **"Participant"** means any Employee who is eligible to participate in the Plan(s) in accordance with ARTICLE II.

3.17 **"Plan Administrator"** means the person(s) or committee as may be appointed from time to time by the Superintendent of the Employer to supervise the administration of the Plan(s). The initial Plan Administrator is the Assistant Superintendent of Finance & Operations.

3.18 **"Plan Year"** for all Plans established hereunder means the 12-month period beginning on January 1 and ending on December 31.

3.19 **"Qualifying Day Care Center"**, for purposes of the Dependent Care Assistance Plan, means a day care center which: (i) complies with all applicable laws and regulations of the State and town, city or village in which it is located; (ii) provides care for more than six individuals (other than individuals who reside at the day care center); and (iii) receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for profit).

3.20 **"Qualifying Individual"**, for purposes of the Dependent Care Assistance Plan, means a Dependent of the Participant who is under the age of 13; or a Dependent of the Participant who is physically or mentally incapable of caring for himself/herself.

3.21 **"Qualifying Services"**, for purposes of the Dependent Care Assistance Plan, means household services and services for the care of a Qualifying Individual which are performed (i) in the home of the Participant; or (ii) outside of the home of the Participant for (a) the care of a Dependent of the Participant under the age of 13, or (b) the care of any other Qualifying Individual who spends at least eight hours a day a the Participant's home. Qualifying Services do not include expenses incurred for services outside of the Participant's home at a camp where the Qualifying Individual stays overnight.

3.22 **"Spouse",** for purposes of the Dependent care Assistance Plan, means the husband/wife of the Participant, subject to the special rules of §21(e)(3) and (4) of the Code. Thus, a spouse who is legally separated from the Participant under a decree of separate maintenance or legal separation is not considered "married".

3.23 **"Student",** for purposes of the Dependent Care Assistance Plan, means an individual who during each of five calendar months during a Plan Year is a full-time student at an Educational Institution.

ARTICLE IV
CAFETERIA PLAN BENEFITS

4.1 **Benefit Options**. Each Plan Year, a Participant may elect to receive one or more of the Benefits described below:

A. **Medical Plan Coverage**. Each eligible Participant may elect to receive coverage for himself/herself and his/her Dependents under the Medical Plan for the Plan Year, and agree to pay the Employee portion of the annual premium cost, if applicable, for such coverage as required by the applicable employment contract, collective bargaining agreement or Board policies and procedures covering such Participant. Federal COBRA law allows a temporary extension of group health insurance to employees and qualified beneficiaries when coverage is lost due to a qualifying event as defined by IRS Code and regulations that were effective as of January 1, 2002.

B. **Cash in Lieu of Medical/Hospitalization Coverage**. Each Participant may elect to waive the medical/hospitalization coverage for himself/herself and his/her Dependents under the Medical Plan (and retain other benefit coverage, if applicable, as specified under the employee's employment agreement), and receive additional compensation in lieu thereof, in the amount specified on the Election Form for such Plan Year provided, however, the Participant must be covered under some other medical/hospitalization plan or policy and must provide proof, satisfactory to the Plan Administrator, of such other coverage, in order to waive coverage under the Medical Plan. The additional compensation will be paid pro-rata on a monthly basis throughout the Plan Year in accordance with the Employer's normal payroll practice.

C. **Premium Conversion Option**. Each Participant who is required to pay for a portion of the premium cost for his/her Medical Plan, Dental Plan, Vision Plan, Disability Plan or Life Insurance Plan coverage may also elect to reduce his/her compensation (through payroll deduction) and pay his/her portion of such premium cost with pre-tax dollars. The amount of payroll deduction will be automatically adjusted to take into account any change in the premium cost for Medical Plan, Dental Plan, Vision Plan, Disability Plan and/or Life Insurance Plan coverage that occurs during the Plan Year.

D. **Medical Expense Reimbursement Plan**. At such time as the Medical Expense Reimbursement Plan becomes effective, as provided for in Section 2.1 above, each Participant may elect to reduce his/her compensation by a specified amount and/or receive from the Employer a contribution amount specified in the collective bargaining agreement with the PEA and set forth on the Election Form, not to exceed the limitations set forth in Section 6.3 of the Medical Expense Reimbursement Plan, and become eligible to receive reimbursement for Eligible Medical Care Expenses incurred by the Participant for himself/herself and/or his/her Dependents during the Plan Year.

E. **Dependent Care Assistance Plan.** At such time as the Dependent Care Assistance Plan becomes effective, as provided for in Section 2.1 above, each participant may elect to reduce his/her compensation by a specified amount set forth in the Election Form, not to exceed the limitations set forth in Section 7.3 of the Dependent Care Assistance Plan, and become eligible to receive reimbursement for Eligible Employment Related Expenses incurred by the Participant during such Plan Year.

4.2 **New Participants**. Any Participant who commences participation other than on the first day of the Plan Year shall be entitled to Benefits only during the remaining months in the Plan Year after his/her Election Form is filed with the Plan Administrator.

4.3 **Compensation Reduction**. Each Participant who elects to receive a Benefit under the Medical Expense Reimbursement Plan and/or Dependent Care Assistance Plan, after such Plans have become effective, shall consent, in writing on the Election Form, to have his/her compensation reduced for such Plan Year by the total of the Annual Medical Expense Reimbursement Amount and the Annual Dependent Care Assistance Amount chosen by such Participant for such Plan Year in accordance with the Employer's normal payroll practices. In addition, each Participant who elects the Premium Conversion Option shall agree on the Election Form to have his/her compensation reduced by the Employee portion of the premium costs for his/her Medical Plan, Dental Plan, Vision Plan, Disability Plan or Life Insurance Plan coverage, and must agree to have such payroll deduction adjusted automatically during the Plan Year for any increase or decrease in the premium cost for such coverage occurring during the Plan Year, unless a "change in status" occurs, as defined in Section 5.5 below.

4.4 **Coverages Provided Under Separate Plans**. Coverage and Benefits under the Medical Plan, Dental Plan, Vision Plan, Disability Plan and Life Insurance Plan will be provided under the separate group medical/hospitalization, dental, vision, disability and life insurance contract(s)/plan(s) sponsored by the Employer, and not under this Cafeteria Plan. The type and amount of benefits available under the Medical, Dental, Vision, Disability and Life Insurance Plans (including deductibles and co-pays) and the eligibility and coverage requirements under the Medical, Dental, Vision, Disability and Life Insurance Plans (including pre-existing illness rules, coverage limits and coordination of benefit rules) shall be as provided in such separate contract(s)/plan(s). Similarly, if a Participant elects to become eligible for reimbursement under the Medical Expense Reimbursement Plan and/or under the Dependent Care Assistance Plan, after such Plans become effective, such reimbursement/coverage will be provided under such respective Plans.

ARTICLE V
ELECTION PROCEDURES

5.1 **Election Form**. Approximately 30 days prior to the first day of the Plan Year, or upon commencement of employment in the case of a new Employee, the Plan Administrator shall provide to each Participant with an Election Form similar to the sample attached hereto, which form shall reflect the Participant's choice(s) under Section 4.1 for such Plan Year.

5.2 **Election Procedure**. To be effective as of the first day of the Plan Year, or the first day he/she becomes eligible in the case of a new Participant, each Election Form must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator specifies, which date will be no later than the beginning of the Plan Year or the effective date of participation in the case of a new Participant or the subsequent Effective Date of the Medical Expense Reimbursement Plan and/or Dependent Care Assistance Plan.

5.3 **Failure to Complete Election Form**. Any Participant who fails to complete an Election Form for any Plan Year in a timely manner shall be deemed to have elected (1) to receive coverage for himself/herself and his/her eligible dependents under the Medical Plan; (2) to receive his/her full compensation in lieu of electing to make the Premium Conversion Option with respect to the payment of his/her share of any premium cost for his/her Medical Plan, Dental Plan, Vision Plan, Disability Plan or Life Insurance Plan coverage(s); and (3) to receive his/her full compensation in lieu of eligibility for reimbursement under the Medical Expense Reimbursement Plan and the Dependent Care Assistance Plan for such Plan Year.

5.4 **Change of Election by Plan Administrator**. If the Plan Administrator determines, at any time during the Plan Year, that any Plan may fail to satisfy any nondiscrimination rule imposed by the Code or any limitation on Benefits provided to certain Employees, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

5.5 **Change of Election by Participant**. A Participant's election (or failure to elect) is irrevocable by the Participant during the Plan Year, subject to a change in status. A Participant may revoke his/her election for the balance of a Plan Year and file a new Election Form only if both the revocation and the new election are on account of, and consistent with, a "change in status". A "change in status" for this purpose shall have the same meaning as given such term in the regulations under §125 of the Code, and generally, includes the marriage or divorce of the Participant, the death of a Spouse or other Dependent, the birth or adoption of a child, the termination or commencement of employment of a Spouse, the switching from part-time to full-time employment, or vice-versa, of the Participant or his/her Spouse, the taking of an unpaid leave of absence of the Participant or his/her Spouse, and such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under the regulations and rulings of the Internal Revenue Service. Any new election under this Section shall be effective at such time as the Plan Administrator prescribes, in accordance with applicable rules of the Internal Revenue Service. Attachment A, Notice of Right to Change Election is incorporated as part of this plan.

5.6 **Election Period**. The "Election Period" for all Benefits under all Plans established in this document shall be the Plan Year, except in the case of the first Plan Year of each respective Plan, in which case the Election Period shall be the period from the Effective Date of such Plan to the end of that Plan Year.

ARTICLE VI
MEDICAL EXPENSE REIMBURSEMENT PLAN BENEFITS

6.1 **Description of Medical Care Expense Reimbursement Benefits**. At such time as the Medical Expense Reimbursement Plan becomes effective, as provided for in Section 2.1 above, each Participant who elects Medical Care Expense Reimbursement shall be entitled to receive Benefits for the Eligible Medical Care Expenses incurred by the Participant during the applicable Plan Year for himself/herself and/or his/her Dependent(s); provided, however, the total reimbursements paid to a Participant for expenses incurred in a single Plan Year may not exceed the lesser of: (i) the Participant's elected Annual Medical Expense Reimbursement Amount (described in Section 6.2 below) for such Plan Year, or (ii) the Annual Medical Expense Reimbursement Limitation (described in Section 6.3 below) for such Plan Year. The Participant's elected Annual Medical Expense Reimbursement Amount for any Plan Year will be allocated to an account (referred to as the Participant's Medical Expense Reimbursement Account") for his/her benefit during such Plan Year under the Medical Expense Reimbursement Plan.

6.2 **Electing Annual Amount of Medical Care Expense Reimbursement.** A Participant who elects to contribute and/or receive from the Employer a contribution amount specified in the collective bargaining agreement with the PEA under the Medical Expense Reimbursement Plan and become eligible for reimbursement for Eligible Medical Care Expenses incurred during such Plan Year must: (1) specify the maximum amount of reimbursement for which he/she is applying for such Plan Year prior to the commencement of the Plan Year (pursuant to ARTICLES IV and V), to be indicated on the Election Form as a total amount for the entire Plan Year (referred to as the Participant's "Annual Medical Care Expense Account", and (2) agree to have his/her compensation for such Plan Year reduced by such amount.

6.3 **Limitations on Benefits**. The maximum reimbursement for which any Participant may apply for any Plan Year is **$2,550**. After December 31, 2014 the IRS may elect to increase this amount and link it to an inflationary increase. This amount is referred to as the "Annual Medical Expense Reimbursement Limitation". In addition, each Participant shall be entitled to reimbursement only for Eligible Medical Care Expenses incurred during the applicable Plan Year, and incurred during the period that he/she is a Participant under the Medical Expense Reimbursement Plan. If a Participant becomes ineligible to participate in the Plan or ceases to be an Employee, such Participant may continue to be eligible for reimbursement of Eligible Medical Expenses incurred after the date he/she becomes ineligible or ceases to be an Reimbursement Amount actually deducted from such Participant's compensation and allocated to his/her Medical Expense Reimbursement Account until the end of the Plan Year. In addition, such Participant may elect to have the balance of his/her elected Annual Medical Expense Reimbursement Amount for such Plan Year which has not already been contributed to the Plan deducted from his/her final paycheck, and continue to be eligible for reimbursement of Eligible Medical Care Expenses incurred after the date he/she becomes ineligible or ceases to be an Employee, until the end of said Plan Year to the maximum amount of reimbursement for which such

Participant applied for such Plan Year. Any unused (unreimbursed) portion of such Participant's Medical Expense Reimbursement Account for each Plan Year shall be forfeited as provided in Section 6.5 below. If an Employee terminates employment before the end of the Plan Year, any unused (unreimbursed) portion of such Participant's Medical Reimbursement Account may be used to purchase COBRA insurance coverage. Such use of the funds must be made in writing and the request sent to the Plan Administrator.

6.4 **Application for Reimbursement.** In order to be entitled to Benefits under the Medical Expense Reimbursement Plan, the Participant shall deliver, or cause to be delivered, to the Plan Administrator or Designee reasonable proof, satisfactory to the Plan Administrator or Designee, of the incurrence of the eligible Medical Care Expenses during the applicable Plan Year. In addition, a properly completed Request for Reimbursement Form, with the proper invoices/receipts attached thereto, must be signed by the Participant and submitted to the Plan Administrator or Designee in order for the Participant to be entitled to a reimbursement. Reimbursements will be paid no later than the end of the calendar month following the month in which the Reimbursement Form is properly submitted to the Plan Administrator or Designee. Any Request for Reimbursement Form relating to expenses incurred in a Plan Year must be received by the Plan Administrator or Designee within 60 days following the close of such Plan Year or the Participant's termination of participation in the case of the Plan Year in which such Participant's employment terminates, unless the Participant elects to continue his/her participation through the end of the Plan Year, as provided above.

6.5 ***GRACE PERIOD*** - The employer has added a two and a half month grace period to the end of the plan year. The grace period ends March15th. This grace period extends the time an individual can incur an eligible claim. Any claim incurred during the two and a half month grace period will count toward any funds remaining in the spending account from the previous plan year. This change was made possible due to IRS Notice 2005-42.

6.6 **Forfeiture of Unused Medical Expense Reimbursement Amount.** Upon the completion of each Plan Year, the total unused (unreimbursed) portion of each Participant's Medical Expense Reimbursement Account shall be forfeited (lost) by the Participant; and the Employer, will use such forfeited amounts to first defray the expense of administering the Plans, and secondly apply such amounts to reduce the cost of participation in the Plans for all Participants for any subsequent Plan Year, subject to the limitations of §125 of the Code and the regulations thereunder.

ARTICLE VII
DEPENDENT CARE ASSISTANCE PLAN BENEFITS

7.1 **Description of Dependent Care Assistance Benefits.** At such time as the Dependent Care Assistance Plan becomes effective, as provided for in Section 2.1 above, each Participant who elects to receive a Benefit under the Dependent Care Assistance Plan shall be eligible to receive reimbursement for all Eligible Employment Related Expenses incurred by such Participant or such Participant's Spouse during the applicable Plan Year; provided, however, the total reimbursements made to any Participant for expenses incurred in a single Plan Year may not exceed the lesser of: (i) the Participant's elected Annual Dependent

Care Assistance Amount (described in Section 7.2 below) for such Plan Year, or (ii) the Annual Dependent Care Assistance Limitation (described in Section 7.3 below) for such Plan Year. The Participant's elected Annual Dependent Care Assistance Amount for any Plan Year will be allocated to an account (referred to as the participant's "Dependent Care Assistance Account") for his/her benefit during such Plan Year under the Dependent Care Assistance Plan.

7.2 **Electing Annual Amount of Dependent Care Reimbursement.** A Participant who elects to contribute under the Dependent Care Assistance Plan and become eligible for reimbursement for Eligible Employment Related Expenses incurred during such Plan Year must: (1) specify the maximum amount of reimbursement for which he/she is applying for such Plan Year prior to the commencement of the Plan Year (pursuant to ARTICLES IV and V), to be indicated on the Election Form as a total amount for the entire Plan Year (referred to as the Participant's "Annual Dependent Care Assistance Amount"), and (2) agree to have his/her compensation for such Plan Year reduced by such amount.

7.3 **Limitation on Benefits.** The maximum reimbursement for which any Participant may apply for any Plan Year is $5,000. Each participant shall be entitled to reimbursement only for Eligible Employment Related Expenses incurred during the applicable Plan Year and incurred during the period that he/she is a Participant in the Dependent Care Assistance Plan. If a Participant becomes ineligible to participate in the Plan or ceases to be an Employee, such participant shall have the choice to either (1) continue to be eligible for reimbursement of Eligible Employment Related Expenses incurred after the date he/she becomes ineligible or ceases to be an Employee to the extent of the then remaining balance of his/her Dependent Care Assistance Account under the Dependent Care Assistance Plan until the end of the Plan Year, or (2) have the balance of his/her elected Annual Dependent Care Assistance Amount for such Plan Year which has not been contributed to the Plan deducted from his/her final paycheck, and continue to be eligible for reimbursement of Eligible Employment Related Expenses incurred after the date he/she becomes ineligible or ceases to be an Employee, to the maximum amount of reimbursement for which such Participant applied for such Plan Year. Any unused (unreimbursed) portion of such Participant's Dependent Care Assistance Account for each Plan Year shall be forfeited as provided in Section 7.5 below.

The maximum reimbursement for which any Participant may apply under the Dependent Care Assistance Plan for any Plan Year is as follows:

A. A Participant who is not married as of December 31 of any calendar year may not receive reimbursement for Eligible Employment Related Expenses incurred by him/her for such calendar year in excess of his/her Earned Income for such calendar year. A Participant who is married as of December 31 of any calendar year may not receive reimbursement for Eligible Employment Related Expenses incurred by him/her for such calendar year in excess of the lesser of: (i) the Participant's Earned Income for such calendar year; or (ii) the Earned Income of such Participant's Spouse for such calendar year. In addition, no Participant may receive more than (ii) the Earned Income of such Participant's Spouse for such calendar year. In addition, no Participant may receive more than (i) his/her elected

Annual Dependent Care Assistance Amount for any Plan Year, or (ii) the amount excludable with respect to such Participant under §129(a) of the Code for any calendar year. In general, this excludable amount is $5,000 ($2,500 for a married Participant filing a separate return) for the calendar year. The limitation described in this Section is referred to as the "Annual Dependent Care Assistance Limitation".

B. For purposes of the foregoing limitations, a Spouse of a Participant who is not employed during the calendar year in which the Participant incurs Eligible Employment Related Expenses, and which Spouse is either incapacitated or a Student, shall be deemed to have Earned Income for each month during which such Spouse is either incapacitated or a Student of: (i) $200, if there is one Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses; or (ii) $400, if there is more than one Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses.

7.4 **Application for Reimbursement**. In order to be entitled to Benefits under the Dependent Care Assistance Plan, the Participant shall deliver, or cause to be delivered, to the Plan Administrator or Designee reasonable proof, satisfactory to the Plan Administrator or Designee, of the incurrence of the Eligible Employment Related Expenses for a Qualifying Individual during the applicable Plan Year. Each Participant who desires to receive Benefits for Eligible Employment Related Expenses incurred for Qualifying Services must submit to the Plan Administrator or Designee a statement containing the following information:

A. The Qualifying Individual(s) for whom the Qualifying Services were performed:

B. The nature of the Qualifying Services performed for which the Participant seeks reimbursement or payment;

C. The relationship, if any, of the person performing the Qualifying Services for the Participant;

D. If the Qualifying Services were performed by a dependent of the Participant, the age of the Dependent;

E. A statement as to where the Qualifying Services were performed;

F. If any of the Qualifying Services were performed outside of the Participant's home, a statement as to whether the Qualifying Individual for whom such Qualifying Services were performed spends at least eight hours a day in the Participant's home;

G. If the Qualifying Services were performed in a day care center, a statement that: (i) the day care center complies with all applicable laws of the State of Michigan and the town, city or village in which it is located; (ii) the day care center provides care for more than six individuals (other than individuals residing at the center); and (iii) the amount of the fee paid to the center; and

H. If the Participant is married and the Participant's Spouse is unemployed, a statement that the Spouse is either incapacitated or a full-time Student attending an Educational Institution, and the months during the year in which said Spouse will attend such Educational Institution.

In addition, a properly completed Request for Reimbursement Form, with the additional information identified above attached thereto, must be completed and signed by the Participant, and submitted to the Plan Administrator or Designee, in order for the Participant to be entitled to a reimbursement. Reimbursements will be paid no later than the end of the calendar month following the month in which the Reimbursement Form is properly submitted to the Plan Administrator or Designee. Any Request for Reimbursement Form relating to expenses incurred in a Plan Year must be received by the Plan Administrator within 60 days following the close of such Plan Year or the Participant's termination of participation in the case of the Plan Year in which such Participant's employment terminates, unless the Participant elects to continue his/her contributions and participation through the end of the Plan Year.

7.5 ***GRACE PERIOD*** - The employer has added a two and a half month grace period to the end of the plan year. The grace period ends March15th. This grace period extends the time an individual can incur an eligible claim. Any claim incurred during the two and a half month grace period will count toward any funds remaining in the spending account from the previous plan year. This change was made possible due to IRS Notice 2005-42.

7.6 **Forfeiture of Unused Dependent Care Reimbursement Amount.** Upon the completion of each Plan Year, the total unused (unreimbursed) portion of each Participant's Dependent Care Assistance Account shall be forfeited (lost) by the Participant; and the Employer, in its sole discretion, will use such forfeited amounts to first help defray the expense of administering the Plans established hereunder, and second apply such amounts to reduce the cost of participation in the Plans for all Participants for any subsequent Plan Year, subject to the limitations of §125 of the Code and the regulations thereunder.

7.7 **Statement of Expenses**. On or before April 30, the Plan Administrator or Designee shall furnish to each Participant a written statement showing the amounts paid, or expenses incurred by the Dependent Care Assistance Plan in providing Eligible Employment Related Expenses to such Participant during the previous year.

ARTICLE VIII
ADMINISTRATION OF PLANS

8.1 **Plan Administrator.** The administration of the Plans established in this document shall be under the supervision of the Plan Administrator. The Superintendent of the Employer shall have the right to appoint and remove the Plan Administrator at any time. It shall be a duty of the Plan Administrator to see that the Plans are carried out, in accordance with their terms, without discrimination. The Plan Administrator shall have full power to administer the Plans, subject to any applicable requirements of law and a Participant's rights to review and appeal as set forth in ARTICLE X. For this purpose, the Plan Administrator's powers shall include, but

shall not be limited to, the following authority, in addition to all other powers provided in this document:

A. to make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;

B. To interpret the Plans, the Plan Administrator's interpretation to be final and conclusive on all persons claiming reimbursement or Benefits under any Plan;

C. To decide all questions concerning any Plan and the eligibility of any person to participate in any Plan and his/her commencement and termination of participation dates;

D. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering any Plan; and

E. To allocate and delegate the Plan Administrator's responsibilities under any Plan, and to designate other persons to carry out any of the Plan Administrator's responsibilities under any Plan, any such allocation, delegation or designation to be in writing.

Any decisions to be made with respect to the eligibility, entitlement, payment or reimbursement of Benefits to, or for the benefit of, the acting Plan Administrator shall be made or ratified by an authorized administrator of the Employer who is not the Plan Administrator.

8.2 **Examination of Records**. The Plan Administrator shall make available to each Participant such records under any Plan established in this document as pertain to him/her, for examination at reasonable times during normal business hours.

8.3 **Reliance on Receipts, Etc**. In administering any Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all receipts, papers, statements, certificates, opinions and reports which are made or furnished by any Employee, Participant, accountant, counsel or other agent employed or engaged by the Plan Administrator.

8.4 **Funding**. The coverage under the Medical Plan is funded in part by the Employer and in part by the Employee. The Medical Expense Reimbursement Plan and Dependent Care Assistance Plan, when they become effective, are funded solely through Employee contributions (through payroll deductions).

8.5 **Information to be Furnished**. Participants shall provide the Employer and the Plan Administrator with such information, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plans.

8.6 **Limitation of Rights**. Neither the establishment of any Plan nor any amendment thereof, nor the payment of any Benefits, shall be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Plan Administrator, except as specifically provided herein. In the

event that the Employer shall fail to obtain coverage for any Participant or Dependent under the Medical Plan, Dental Plan, Vision Plan, Disability Plan and/or Life Insurance Plan, as elected by the Participant, the Employer shall only be liable for the premium cost that it would have paid for the months that such coverage should have been in force, and shall not be liable for the cost of any Benefit that would have been received had the coverage been in force.

8.7 **Nature of Benefits**. The Benefits provided hereunder are in the form of compensation to the Participant in return for services rendered, or to be rendered, by the Participant to the Employer.

8.8 **Non-Alienation**. No Benefit shall in any manner be alienated, sold, transferred, assigned, pledged or subjected to attachment, garnishment or encumbrance of any kind.

8.9 **Severability**. The invalidity of any provision of this document shall not invalidate the remainder hereof.

8.10 **Gender**. As used herein, the masculine shall include the feminine and neuter, and the singular, the plural, and vice versa, whenever such meanings would be appropriate.

8.11 **Governing Law**. This document, the Plan and any matter relating hereto shall be governed by, and interpreted in accordance with, the laws of the State of Michigan.

8.12 **Employment Relationship**. Nothing in this document shall be construed to create, continue or modify the employment relationship of any Employee. Nothing in this document shall be deemed or construed to modify any collective bargaining agreement.

ARTICLE IX
AMENDMENT AND TERMINATION OF PLANS

Notwithstanding anything herein to the contrary, the Employer reserves the right to alter, amend, terminate or revoke any Plan or Benefit established by this document, at any time and from time to time, and to change the provider of any coverage under the Medical Plan, Dental Plan, Vision Plan, Disability Plan and Life Insurance Plan, and no Employee, Participant, Dependent or any other person (whether or not then absent from work because of illness, personal injury, disability or sickness, and whether or not then under medical, dental, psychiatric, surgical or hospital treatment or care) shall have any further right, title, interest or claim, legal or equitable, in or to any reimbursement or Benefit payable under such Plan beyond the Plan Year in which such Plan or Benefit is terminated. The Employer will provide a 60 day written notice of any alteration, amendments or termination of the Plan to participants.

ARTICLE X
CLAIMS PROCEDURE

Upon the receipt of a copy of this document or an Election Form from the Employer or upon the initial receipt of reimbursement or Benefits under any Plan which, in the opinion of the Participant, is of a different amount, or paid pursuant to a method different, than what the Participant believes he/she is entitled to:

The Participant may mail a formal written claim for Benefits to the Plan Administrator explaining in detail the reasons for the claim. Within 90 days from the receipt of the Participant's claim for Benefits, the Plan Administrator shall by written response inform the Participant of a decision to allow or disallow, in whole or in part, such claim for Benefits, attaching thereto the detailed reason(s) for such decision and the rules for requesting a review. In a special case, the Plan Administrator may take up to an additional 90 days to decide; provided notice is given to the Participant explaining why more time is needed.

In the event the Plan Administrator's decision is to disallow, in whole or in part, the Participant's claim for Benefits, the Participant shall have the right, within 60 days from the review, the Participant shall be allowed to see all Plan documents and other papers which affect his/her claim, and shall be allowed to have a representative present at the review. If a claim is denied because the Plan Administrator needs more information to make a decision, the Plan Administrator must notify the Participant of the additional information needed.

Within 60 days after the request for review is filed with the Plan Administrator, the review shall be conducted and a decision rendered. The review shall be conducted by the Plan Administrator or any other person or persons designated by the Employer, and such reviewing person(s) shall have the authority to make a final decision on the claim. In a special case, the person(s) conducting the review may take up to an additional 60 days to render a decision; provided that notice is given to the Participant explaining why more time is needed.

IN WITNESS WHEREOF, the Employer has caused this document to be executed in its name and behalf as of the day and year first above written.

PINCKNEY COMMUNITY SCHOOLS,
A General Powers School District

By: Michelle Crampo
President, Board of Education

Date: December 4, 2014

ATTACHMENT A
NOTICE OF RIGHT TO CHANGE ELECTION

Under the Cafeteria Plan and in accordance with the Regulations issued by the Internal Revenue Service, you may revoke or change your elections upon the occurrence of the events described in this Notice. However, unless otherwise stated below, your change must be both "on account of" and "consistent with" the event which permits the change or revocation to be made. These permissible events are taken from the IRS Regulations, and are subject to further change and interpretation by the IRS.

1. Changes in Family or Employment Status of You or a Dependent. You may revoke your election and make a new election under the Cafeteria Plan for the remainder of the Plan Year, for any benefit, if any of the following events occur:

a. An event which changes your legal marital status: marriage, divorce, legal separation, annulment or death.
b. An event which changes the number of your dependents; death, birth, adoption and placement for adoption.
c. An event which changes your, your spouse's or a covered dependent's employment status: termination or commencement of employment, strike or lock-out, taking or returning from an unpaid leave of absence, a change in worksite, and switching from full-time to part-time status (but only if such switch effects eligibility for coverage or benefits).
d. An event which changes the eligibility for coverage of a covered dependent (e.g. attainment of a certain age, student status, etc.) and
e. An event which changes your, your spouse's or a covered dependent's place of residence.

In addition, if the eligibility conditions of this Cafeteria Plan, or the cafeteria plan (or other employee benefit plan) of your spouse's employer or the employer of a covered dependent, depend on the employment status of that individual, and if there is a change in that individual's employment status which results in that individual becoming (or ceasing to be) eligible under this plan, then that change also constitutes a change in employment under this Cafeteria Plan.

In the case of a change in family or employment status, you must file a new Election Form to make a change, and both the revocation of your current election and the making of a new election, must be "on account of, and consistent with," the change in family or employment status.

Example: If the event is your divorce or the death of your spouse or a covered dependent attaining an age which makes him/her ineligible to continue as your dependent, then you may only change your current Election Form to cancel coverage for such ineligible individual (the former spouse, deceased individual or older dependent). Any change in your Election Form to cancel coverage for any other individual would not be "on account of and consistent with" the event which occurred.

2. Significant Cost or Coverage Changes. If you elected the Premium Conversion Option, or if you chose a particular group insurance coverage which requires you to pay a portion of the premium cost, then you may revoke your election and make a new election for the remainder of the Plan Year if, during the Plan Year there is a significant increase in the cost of such group insurance, or a significant change in the type of coverage under such group insurance plan. However, this rule does not apply to the Medical Expense Reimbursement Plan; and only applies to the Dependent Care Assistance Plan (or a Cafeteria Plan election with respect thereto) if the cost change is imposed by a dependent care provider who is not related to you.

In addition, if a new benefit or coverage option is added or is significantly improved, you may revoke your election (whether or not you have previously made an election or elected that benefit or coverage option) and make a new election (on a prospective basis) for coverage under the new or improved benefit or coverage option.

Again you must file a new Election Form to make a change, and your change must be both on account of and consistent with the event which occurred.

Example: if the cost of the Medical Plan coverage significantly increases during the Plan Year, you may either increase your payroll deduction to cover the cost increase, or you may change your election and either cancel the Medical Plan coverage or select a less expensive Medical Plan, if one is offered.

Example: If during the Plan Year, another benefit plan or option is made available or if a benefit plan or option is reduced or eliminated, then you can change your election and make a new election on a prospective basis. This would also be the case if your spouse's employer's cafeteria plan makes another option available or eliminates a chosen option.

3. Additional Change in Coverage Rules. As noted above, if you, your spouse or a dependent have a "significant curtailment of coverage" under this Cafeteria Plan or under another employer's cafeteria plan that is not considered a "complete loss of coverage", you may revoke your election and make a new election (on a prospective basis only) for coverage under another benefit package option providing similar coverage. If such "significant curtailment of coverage" is a "complete loss of coverage" then you may also elect to drop that coverage altogether (on a prospective basis). Coverage is considered "significantly curtailed" only if there is an overall reduction in coverage provided under the plan "so as to constitute reduced coverage overall." Thus, in most cases, the loss of one physician in a network would not constitute a significant curtailment. A "loss of coverage" means a complete loss of coverage under the benefit package option or other coverage option, and includes the following:

a. The elimination of a benefits option package,
b. An HMO ceasing to be available in the area where you live,
c. Losing all coverage under the option by reason of an overall lifetime or annual limitation,
d. A substantial decrease in the medical care providers under the option (e.g. a major hospital ceasing to be a member of a preferred provider network, or many physicians ceasing the participate in a preferred provider network or HMO), or
e. A reduction in the benefits for a specific type of medical condition or treatment with respect to which you or your spouse or a dependent are currently in treatment.

4. Change in Coverage under Spouse's of Dependent's Employer's Plan. As noted above, you may make a prospective change that is both on account of and consistent with a change made under another employer plan (including another plan sponsored by this employer or another employer), if (i) the other cafeteria plan or benefit plan permits its participants to make an election change that is permitted under this Notice, or (ii) our Cafeteria Plan has a Plan Year difference from the plan year or period of coverage under the other cafeteria plan or benefit plan.

Example: Your spouse works for another employer and participates in its cafeteria plan, which operates on a fiscal year beginning July 1. You elect coverage for yourself only under the Medical Plan under this Cafeteria Plan, and your spouse elects coverage for himself/herself only under his/her employer's medical plan and cafeteria plan. In July, your spouse elects no medical coverage under his/her employer's cafeteria plan. This will permit you to change your election under this Cafeteria Plan and switch to family coverage under the Medical Plan for the remainder of the Plan Year of this Cafeteria Plan.

5. Judgment Ordering or Permitting Change. You may change your election to provide for a child as a result of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for your child or for a foster child who is dependent on you, if the order requires coverage for the child under this Employer's plan, or if the order requires your spouse, former spouse, or another individual to provide coverage for such child. After December 31, 2001, the other coverage, if so ordered, must actually be provided, or order to cancel the election under this Cafeteria Plan.

6. Entitlement to Medicare or Medicaid. If you or your spouse or a dependent are enrolled in the Medical Plan and become entitled to coverage (i.e. become enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), you may make a prospective election change to cancel or reduce coverage for such individual under the Medical Plan. In addition, if you, your spouse or a dependent lose eligibility for Medicare or Medicaid you may make a prospective change to increase coverage for that individual under the Medical Plan.

7. Family and Medical Leave Act (FMLA) Changes. You may revoke your election for the balance of a Plan Year, if you are on an unpaid leave of absence under the Family and Medical Leave Act ("FMLA"). If you are returning from an unpaid FMLA leave, you are entitled to be reinstated in the group health plan(s) (i.e., medical/dental/vision plans) and in the Medical Expense Reimbursement Plan, if your group health plan coverage and/or participation in the Medical Expense Reimbursement Plan terminated while you were on an unpaid FMLA leave (either by revocation or non-payment of premiums/contributions). You are entitled to be reinstated on the same terms as prior to taking the unpaid FMLA leave (including family or dependent coverage). However, you will have no greater rights to benefits for the remainder of the Plan Year than a Participant who has been continuously working during the Plan Year. The following additional rules apply if you are on an unpaid FMLA leave:

a. If you were making premium payments or contributions under the Cafeteria Plan or Medical Expense Reimbursement Plan, and you chose to continue the group health plan coverage (s) and/or your participation in the Medical Expense Reimbursement Plan while on the unpaid FMLA leave, you are required to continue to pay/make your share of the premium payments/contributions for such continued coverage/participation, in the same amount as you were paying/making prior to the unpaid FMLA leave. In the event you elect to continue group health plan coverage and/or participation in the Medical Expense

Reimbursement Plan, and you continue to pay your portion of the premium for such coverage, and make your contribution under the Medical Expense Reimbursement Plan, the Company will continue to make the same contribution to the cost of such coverage/participation as it was making prior to the unpaid FMLA leave. You may either pre-pay your premium amount/contributions for the remainder of the calendar year in which the unpaid FMLA leave commences or you may continue to pay/make such premium amounts/contributions on the same periodic basis as existed prior to the unpaid FMLA leave. However, no premium amount/contributions may be pre-paid beyond the end of the calendar year in which the pre-payment is made.

b. Unless otherwise required by law or provided in a collective bargaining agreement that covers you, the group health coverage and participation in the Medical Expense Reimbursement Plan will cease upon your failure to pay the required premium payments/contributions while on the unpaid FMLA leave.

c. If your participation under the Medical Expense Reimbursement Plan terminates while you are on an unpaid FMLA leave, you will not be entitled to receive reimbursements for claims incurred during the period when the participation is terminated. If you subsequently elect to be reinstated in the Medical Expense Reimbursement Plan upon your return from the unpaid FMLA leave for the remainder of the Plan Year, you may not retroactively elect participation for claims incurred during the period when the participation was terminated. In addition, if your participation in the Medical Expense Reimbursement Plan terminated during an unpaid FMLA leave, and you reinstate your participation for the remainder of the Plan Year upon your return from the unpaid FMLA leave, your annual Medical Expense Reimbursement Limitation for such Plan Year will be prorated from the period during the unpaid FMLA leave for which no contributions were paid, and reduced by prior reimbursements.

d. Upon your return from an unpaid FMLA leave, you may make a new election for the remainder of the Plan Year, if your return from leave without pay constitutes a "change of family status" as described above.

e. These rules do not apply if you are on a paid FMLA leave.

8. HIPAA Special Enrollment Right. You may revoke your election for coverage under the Medical Plan during the Plan Year, and make a new election that corresponds with the special enrollment rights provided in §9801(f) of the Code and the IRS Regulations thereunder.

ATTACHMENT B

Additional Permitted Election Changes for Health Coverage under § 125 Cafeteria Plans

Notice 2014-55

PURPOSE

This notice expands the application of the permitted change rules for health coverage under a § 125 cafeteria plan (cafeteria plan). In particular, this notice addresses two specific situations in which a cafeteria plan participant may wish to revoke, during a period of coverage (commonly a plan year), the employee's election for employer-sponsored health coverage under the cafeteria plan in order to purchase a Qualified Health Plan through a competitive marketplace established under § 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace (Marketplace). The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the employer's group health plan. (This may occur, for example, under certain employer plan designs intended to avoid any potential assessable payment under § 4980H of the Internal Revenue Code.) The second situation involves an employee participating in an employer's group health plan who would like to cease coverage under the group health plan and purchase coverage through a Marketplace without that resulting either in a period of duplicate coverage under the employer's group health plan and the coverage purchased through a Marketplace or in a period of no coverage.

This notice permits a cafeteria plan to allow an employee to revoke his or her election under the cafeteria plan for coverage under the employer's group health plan (other than a flexible spending arrangement (FSA)) during a period of coverage in each of those situations provided specified conditions are met. The Treasury Department and the IRS intend to modify the regulations under § 125 consistent with the provisions of this notice, but taxpayers may rely on this notice immediately.

BACKGROUND

Section 125(d)(1) defines a cafeteria plan as a written plan maintained by an employer under which all participants are employees, and all participants may choose among two or more benefits consisting of cash and qualified benefits. Section 125(f) defines a qualified benefit as any benefit which, with the application of § 125(a), is not includable in the gross income of the employee by reason of an express provision of the Code (with certain exceptions). Qualified benefits include employer-provided accident and health plans excludable from gross income under §§ 106 and 105(b), but exclude long term care insurance and certain Qualified Health Plans offered through Marketplaces.

Proposed § 1.125-1(c)(1)(iii) of the Income Tax Regulations, consistent with longstanding rules for cafeteria plans, states that a written cafeteria plan must provide that elections are irrevocable except to the extent that the optional change in status rules in Treas. Reg. § 1.125-4 have been included in the cafeteria plan. Treas. Reg. § 1.125-4 provides rules on the circumstances in which a cafeteria plan may permit changes to elections under the plan. Cafeteria plans are not required to allow any of the changes permitted under Treas. Reg. § 1.125-4.

Treas. Reg. § 1.125-4(c) permits a cafeteria plan to allow an employee to revoke an election during a period of coverage with respect to coverage under an accident or health plan as defined in Treas. Reg. § 1.105-5, and make a new election for the remaining portion of the period, if under the facts and circumstances (i) a change in status occurs, and (ii) the election change satisfies the consistency requirements of Treas. Reg. § 1.125-4(c)(3). A change of status for this purpose includes changes in employment status as described in Treas. Reg. § 1.125-4(c)(2)(iii). A change in employment status for this purpose only includes a change in an individual's employment status that results in a change in the individual's eligibility for coverage under the group health plan. Thus, under the existing regulations, a change in employment status that does not result in an employee either becoming or ceasing to be eligible for coverage under the group health plan is not a change in status for which a plan may allow the employee to revoke an election of health coverage under the cafeteria plan during a period of coverage.

Even if the change in status results in a change in eligibility for coverage under the group health plan, any revocation of an election must meet the consistency requirements of Treas. Reg. §§ 1.125-4(c)(3)(i) and 1.125-4(c)(3)(iii). Those requirements provide that if an employee's change in status only results in some of the individuals covered by a group health plan due to their relationship to the employee ceasing to satisfy eligibility requirements for coverage, the employee's election under the cafeteria plan to cancel coverage under the group health plan for any individual other than the individuals losing eligibility fails to correspond with that change in status. Similarly, if a change in status results in an individual gaining eligibility for coverage under a group health plan, an employee's election to cease or decrease coverage for that individual under the cafeteria plan corresponds with the change in status only if the individual enrolls in the coverage for which the individual is newly eligible. That is, an individual gaining eligibility for coverage under a group health plan cannot use that change in status to revoke coverage. Treas. Reg. § 1.125-4(b) permits a cafeteria plan to allow an employee to revoke an election under the group health plan during a period of coverage and to make a new election that corresponds with the special enrollment rights under § 9801(f). Special enrollment rights under § 9801(f) concern rights to enroll in a group health plan due to loss of other coverage or certain family events, but do not include the ability to enroll in a Qualified Health Plan through a Marketplace.

Interaction with § 4980H

Under § 4980H, an applicable large employer is subject to an assessable payment if the applicable large employer does not offer minimum essential coverage to its full time employees and one or more full time employees receive the premium tax credit under § 36B. Under Treas. Reg. § 54.4980H-3(d), an applicable large employer may use the look-back measurement method to determine the status of an employee as full-time or not full-time. Under the look-back measurement method, for purposes of § 4980H, an employee determined to be full-time based on hours of service during a measurement period must be treated as a full-time employee during a subsequent stability period, regardless of the employee's hours of service during the stability period. Thus, under the look-back measurement method, an employee could have a change in employment status (for example, a change from a full-time position to a part-time position) resulting in a reduction in hours that does not change the employee's status as a full-time employee for purposes of § 4980H, at least for some period of time. Under certain health plan designs intended to avoid any potential assessable payment under § 4980H by offering coverage to employees for all periods during which the employees are classified as full-time employees for § 4980H purposes, the change in employment status would not result in a change in an employee's eligibility for the

group health plan. Because the change in employment status would not result in a change in the employee's eligibility for the group health plan, under Treas. Reg. § 1.125-4(c), the cafeteria plan could not allow the employee to change the employee's election under the cafeteria plan during the period of coverage.

Interaction with Enrollment in a Qualified Health Plan Through a Marketplace

Under the current change in status rules under Treas. Reg. § 1.125-4, a cafeteria plan may not allow an employee to revoke an election under the group health plan during a period of coverage solely to enroll in a Qualified Health Plan through a Marketplace. For an individual enrolled through a cafeteria plan in a group health plan with a calendar plan year, the employee may continue his or her coverage under the plan for the remainder of the plan year and then immediately begin coverage under a Qualified Health Plan purchased through a Marketplace. However, an individual enrolled through a cafeteria plan in a group health plan with a non-calendar plan year might not be able to synchronize the change in coverage to avoid an overlapping period of coverage or a period without coverage because the open enrollment period rules for Marketplaces do not permit the purchase of coverage commencing upon the end of the non-calendar cafeteria plan year.
Also, under Treas. Reg. § 1.125-4(b) a cafeteria plan may allow an employee to revoke an election under a group health plan during a period of coverage and to make a new election that corresponds with special enrollment rights under § 9801(f). Special enrollment rights under § 9801(f) relate only to enrollment in another group health plan, not to enrollment in a Qualified Health Plan offered through a Marketplace. Thus, Treas. Reg. § 1.125-4(b) does not permit a cafeteria plan to allow an employee to revoke an election under a group health plan during a period of coverage and enroll in a Qualified Health Plan offered through a Marketplace as the result of an employee's eligibility to enroll in a Qualified Health Plan during Special Enrollment Period for the Marketplace[1] (even though most of the events giving rise to special enrollment rights under § 9801(f) correspond to the events giving rise to Special Enrollment Periods for a Qualified Health Plan). However, in the case of an event such as a birth or marriage, it may be more advantageous for some individuals to enroll themselves and their families in a Qualified Health Plan rather than to add family members to an employer's group health plan. To permit access to Qualified Health Plans in these cases, this notice permits a cafeteria plan to allow a participating employee to revoke an election in order to obtain coverage through a Marketplace.

[1] Marketplaces must provide Special Enrollment Periods during which qualified individuals may enroll in Qualified Health Plans offered through Marketplaces. See 45 CFR 155.420(d)

GUIDANCE

A cafeteria plan may allow an employee to prospectively revoke an election of coverage under a group health plan that is not a health FSA and that provides minimum essential coverage (as defined in § 5000A(f)(1)) provided the following conditions are met:
Conditions for revocation due to reduction in hours of service

(1) The employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee's status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and (2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee,

(2) And any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

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

Conditions for revocation due to enrollment in a Qualified Health Plan

(1) The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

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

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

EFFECTIVE DATE AND PLAN AMENDMENTS

The guidance in this notice is effective on September 18, 2014. The Treasury Department and the IRS intend to amend Treas. Reg. § 1.125-4 to reflect the guidance in this notice. Taxpayers may rely on the guidance in this notice pending further guidance. To allow the new permitted election changes under this notice, a cafeteria plan must be amended to provide for such election changes. The amendment must be adopted on or before the last day of the plan year in which the elections are allowed, and may be effective retroactively to the first day of that plan year, provided that the cafeteria plan operates in accordance with the guidance under this notice and the employer informs participants of the amendment, and provided further that a cafeteria plan may be amended to adopt the new permitted election changes for a plan year that begins in 2014 at any time on or before the last day of the plan year that begins in 2015. However, in no event may an election to revoke coverage on a retroactive basis be allowed.