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**CAFETERIA PLAN**  
PREMIUM REDUCTION OPTION

**SUMMARY PLAN DESCRIPTION**

**AS ADOPTED BY**  
**HOLTON PUBLIC SCHOOLS**

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# Section 125 Cafeteria Plan

## Part 1. Introduction

Your employer (“Employer”) is pleased to sponsor an employee benefit program known as a Cafeteria Plan (“Plan”) for certain Eligible Employees of the Employer. It is called a Cafeteria Plan because you can choose from a selection of different insurance and fringe benefit programs according to your needs. Your Employer gives you this opportunity to use a salary conversion arrangement through which you can use pre-tax dollars to pay for your benefits instead of paying for the benefits through after-tax payroll deductions. By paying for the benefits with pre-tax dollars, you save money by not having to pay Social Security and income taxes on your salary reduction. However, you may still have the option of paying for your benefits with after-tax dollars.

This Summary Plan Description (“SPD”) describes the basic features of the Plan; how it operates, and how you can get the maximum advantage from it. Refer to Part 6 for the benefit package option(s) available under this plan. The Plan is established pursuant to a plan document into which this SPD is incorporated (i.e. the plan document and this SPD constitute the plan document). However, if a conflict exists between the plan document and this SPD, the plan document will take precedence.

## Part 2. General Information about the Plan

### Q-1 What is the purpose of the Plan?

This Plan is designed to allow Eligible Employees to choose one or more of the benefits offered through the Plan and, using funds provided through employee salary reduction, to pay for the selected benefits with pre-tax dollars. It is established for the exclusive benefit of Participants.

### Q-2 What benefits are offered through the Plan?

The Plan allows you to make your share of the contributions with Pre-tax contributions for qualified benefits (“Benefit Package Options”) offered under the Plan to the extent such benefits are listed in Part 6 below.

You will receive information materials before each enrollment period explaining the various benefit options your Employer is offering for the next Plan Year.

### Q-3 Who can participate in the Plan?

Any employee (as that term is defined in the Plan Document) of the Employer who satisfies the Eligibility Requirements established by the Employer in the Plan Information Summary is eligible to participate in this Plan. You will cease to be a Participant if:

The Plan terminates,

You cease to be eligible for the Plan (e.g. the Participant’s employment is terminated),

You revoke your election to participate, or

The Plan is amended to exclude you or the class of employees of which you are a member.

You may be entitled to temporarily continue coverage under one or more of the Benefit Package Options that provide group health coverage. Refer to the applicable plan summaries for more information on COBRA continuation coverage.

### Q-4 What happens if I terminate employment (or cease to be eligible) and then am rehired (become eligible again) during the same Plan Year?

If you terminate your employment or you cease to be eligible for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then you are rehired or again become eligible within 30 days or less of the date of a termination of employment or cessation of eligibility, then you will be reinstated in the Plan (assuming you otherwise satisfy the eligibility requirements of the Plan) with the same elections you had before termination (subject to any restrictions imposed under the applicable Benefit Package Options). If you are rehired or again become eligible more than 30 days following termination of employment or cessation of eligibility and you are otherwise eligible to participate in the Plan, then you may make new elections.

### Q-5 What happens if I take a leave of absence?

- (a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your group health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).
- (b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

- (c) If you opt to continue your group health coverage, in the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), you may pay your share of the contribution in one of the following ways:
- (i) With after-tax dollars while you are on leave,
  - (ii) You may pre-pay all or a portion of your share of the contributions for the expected duration of the leave with Pre-tax deductions from your pre-leave pay by making a special election to that effect before the date such pay would normally be made available to you. However, pre-payments of Pre-tax deductions may not be utilized to fund coverage during the next Plan Year (except as otherwise permitted by law).
  - (iii) By other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave).

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence and will be applied uniformly to all Participants. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contributions not paid during the leave in a manner agreed upon with the Administrator. The Status Change Matrix will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

- (d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Package Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.
- (e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and your Employer.
- (f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.
- (g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Package Option, the election change rules in Part 2 Q-11 below will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

#### **Q-6 What tax advantages can I gain by participating in the Plan?**

By participating in the Plan, you will not have to pay income tax or Social Security tax on your elections. Following is an illustration of how a hypothetical employee saved on taxes by participating in a cafeteria plan. Let's assume our hypothetical employee makes \$2,500 each month and has 28% withheld for federal withholding and 7.65% for Social Security. The employee's take-home pay before participating in the Plan is \$1,609 a month. Out of that, \$348 a month is paid for insurance benefits. The employee decides to participate in the cafeteria plan. By participating in the Plan and paying contributions on a pre-tax basis under the Plan, the employee saved \$123 a month. Following is a table to better illustrate the example.

Breakdown of Pay Check and Deductions	Not Participating in Cafeteria Plan	Participating in Cafeteria Plan
<b>Gross Monthly Pay</b>	<b>\$2,500.00</b>	<b>\$2,500.00</b>
Less Premium for Major Medical		(348.00)
<b>Taxable Income</b>	2,500.00	2,152.00
<b>Less 28% Federal Withholding</b>	(700.00)	(603.00)
<b>Less 7.65% Social Security Tax</b>	(191.00)	(165.00)
<b>Less Premium for Major Medical</b>	(348.00)	
<b>Spendable Income</b>	<b>\$1,261.00</b>	<b>\$1,384.00</b>

The employee saved \$123 a month or \$1,476 a year by participating in Plan!

This savings result in extra disposable income and this occurs because the employee participated in the Plan and made the required employee contributions before the taxes were withheld. This is just one example of the possible tax savings under the Plan.

**Q-7 How do I become a Participant?**

You become a Participant in the Cafeteria Plan by completing and submitting a Benefit Election Form (or Salary Reduction Agreement) to the Plan Administrator (or its designee identified on the election form) during one of the applicable enrollment periods described in Q-8 below. Your effective date of participation in the Cafeteria Plan is also described in Q-8 below. Enrollment in the Cafeteria Plan does not necessarily result in enrollment in the Benefit Package Options. Coverage under the Benefit Package Options that you elect will begin only as set forth in the summary plan descriptions or other written material for each Benefit Package Option that you elect.

**Q-8 What are the enrollment periods?**

There are three enrollment periods:

1. *Enrollment Period prior to the Effective Date.* This is the enrollment period that occurs before the Plan's Effective Date (as described in the Adoption Agreement). An Election made during this Enrollment Period is effective on the Effective Date of the Plan.
2. *Initial Enrollment Period.* The Initial Enrollment Period is the period during which newly Eligible Employees enroll in the Plan. The Initial Enrollment Period is described in the enrollment material provided by the Plan Administrator. An election to participate that is made during this enrollment period will be effective on the Plan Entry Date.
3. *Annual Enrollment Period.* The Annual Enrollment Period is the period each year in which participants may elect to change and/or continue their elections or Eligible Employees may elect to participate for the next Plan Year. The Annual Enrollment Period is described in your enrollment material that you will receive prior to the Annual Enrollment Period. An election to participate made during this period will be effective on the anniversary date.

If you have the ability to enroll by phone or Internet, separate enrollment periods may be established for paper, telephone, and Internet. Your Employer will tell you what enrollment periods are established for each.

See Q-10 below for what happens when you fail to return a Benefit Election Form during the enrollment period.

**Q-9 How long is my election to participate (or not to participate) effective?**

Your elections (either to participate or not) are for the entire Plan Year, which is usually 12 months. The first Plan Year and the last Plan Year may be for a shorter period. See Part 6 below for the exact dates of your Plan Year.

**Q-10 What happens if I fail to return my Benefit Election Form?**

If you are not currently participating in the Plan and you fail to return a Benefit Election Form before the end of the applicable Enrollment Period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to become a Participant until the next Annual Enrollment Period or following the date you experience a change in status that allows you to enroll mid Plan Year (assuming you timely change your election). If you are currently participating in the Plan and fail to submit a Benefit Election Form by the end of the Annual Enrollment Period for the next Plan Year, your elections for the next Plan Year will depend on which benefits you currently have.

If you have currently elected to pay for one of your Benefit Package Options (other than Health Savings Account (HSA)) with pre-tax contributions, it will be assumed that you want to continue these elections for the next Plan Year (and contribute your share of the cost on a pre-tax basis, adjusted to reflect any increase in the contribution). Otherwise, your election under the Plan will terminate at the end of the Plan Year.

**Q-11 Can I change my election during the Plan Year?**

Generally, you cannot change your election to participate in the Plan or vary the benefits you have selected during the Plan Year, although your election will automatically terminate if you are no longer working for the Employer or you are no longer eligible. You may change your elections only during the Annual Enrollment Period, and then the change will not be effective until the beginning of the next Plan Year.

There are several important exceptions to this general rule. You may change or revoke your previous elections during the Plan Year if you experience one of the events listed below.

Please refer to the Change of Status Matrix (distributed with this SPD) for a table of the qualifying events, the benefits affected by each event, and the possible changes in elections that may take place for each benefit. If you have a qualifying event, you must notify the Plan Administrator within 30 days of the event to enroll or make a change (if applicable) to your existing election.

Note: These rules do not apply to a Code Section 223 Health Savings Account offered under the Cafeteria Plan. See Part 4 below for more information regarding election changes related to the Health Savings Account.

**1. Changes in Status.** If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),
- Change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,
- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student), or
- Change in your, your Spouse's, or your Dependent's place of residence that affects benefit eligibility under a cafeteria plan.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility. A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage, and accidental death and dismemberment coverage), a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or

legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- However, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is still a tax dependent (e.g. a child who lives with you and to whom you provide over half of their support but who has lost eligibility under the Plan).
- *Gain of Coverage Eligibility under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status (as described above), you may elect to either increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects \$10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

**2. Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.

Effective April 1, 2009, if an otherwise eligible employee (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible Employee declined enrollment in medical coverage for the Employee or the Employee's eligible Dependents because of medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, the Employee may be able to elect medical coverage under a Benefit Option for the Employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible

employee and/or dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, the employee may also be able to enroll the Employee, and the Employee's Dependent, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance. Please refer to the group health plan summary description for an explanation of special enrollment rights.

**3. Certain Judgments, Decrees, and Orders.** If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

**4. Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

**5. Change in Cost.** If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Package Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are met.

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

**6. Change in Coverage.** If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed you may revoke your election and elect coverage under another Benefit Package Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are satisfied.

With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

#### **Q-12 How are my Benefit Package Options that I elect paid for under this Plan?**

You may be *required* to pay for any Benefit Package Option coverage that you elect with Pre-tax Contributions. Alternatively, the Employer may allow you to pay your share of the contributions with after-tax contributions. The enrollment material you receive will indicate whether you have to pay with Pre-Tax Contributions or whether you have an option to choose to pay with after-tax contributions.

When you elect to participate both in this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Package Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use

Pre-tax Contributions (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

An Employer may choose to pay for a share of the cost of the Benefit Package Options you choose with Benefit Credits. The amount of Benefit Credits that is applied by the Employer towards the cost of the Benefit Plan Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's sole discretion. The Benefit Credits amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Benefit Credit be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the enrollment material.

The Employer may provide you with employer contributions over which you have discretion to choose how to apply to the various Benefit Package Options available under the Cafeteria Plan. The Benefit Credit amounts provided by the Employer, if any, and any restrictions on their use, will be set forth in the enrollment material.

### **Q-13 What happens if a claim for benefits under the Plan is denied?**

If you are denied a benefit under this Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a benefit under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option, if any.

Step 1: Notice is received from Plan Service Provider. If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. The Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period.

Step 2: Review your notice carefully. Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

The reason(s) for the denial and the Plan provisions on which the denial is based;

A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;

A description of the Plan's appeal procedures and the time limits applicable to such procedures;

A right to request all documentation relevant to your claim.

Step 3: If you disagree with the decision, you may file an appeal. If you do not agree with the decision, and you wish to appeal, you must file a written appeal in accordance with the Notice referenced in Step 1 no later than 180 days of receipt of that Notice. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: Notice of Denial following appeal. If the claim is again denied, you will be notified in writing. If there is only one level of appeal, notice of the denial will be sent no later than 60 days after the appeal is received. See below for more information if the Plan has established two levels of appeal.

Step 5: Review your notice carefully. You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial.

Step 6 (if there is a second level of appeal as indicated in the notice of denial referenced in Step One and/or Four above): If you still disagree with the decision, and you wish to appeal, you must file a second level appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial from the Plan Service Provider (referenced in Step 4). You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

### **Q-14 What effect will Plan participation have on Social Security and other benefits?**

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

## **Part 3. Cash Benefits**

During any one Plan Year, the maximum salary reduction amount a Participant can elect under this Plan cannot exceed the sum of the cost of the Benefit Options offered under this Plan (as identified in Part 6 below). Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation. Except to the extent set forth in the Enrollment material, any Benefit Credits (if offered) not used towards the cost of Benefit Options made available under the Plan will revert back to the employer.

## Part 4. Health Savings Account Contributions

### Q-1 What is a Health Savings Account for which contributions can be made under this Plan?

A Health Savings Account (“HSA”) is a personal savings account established with a Custodian or Trustee to be used primarily for reimbursement of “eligible medical expenses” you (the Account Beneficiary) and your eligible tax dependents (as defined in Code Section 152) incur, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee and the terms of the HSA are set forth in the Custodial or Trust Agreement. The HSA is not an Employer sponsored employee benefit plan. The Employer’s role with respect to the HSA is limited to making an HSA available to you and to making contributions to the HSA on your behalf through this Plan (through non-elective Employer contributions and/or pre-tax salary reductions elected by the Account Beneficiary). The fact that contributions to the HSA are made through this Plan should not be construed as endorsement of the HSA by the Employer. The Employer has no authority or control over the funds deposited in the Account Beneficiary’s HSA. As such, the HSA identified in the Plan Information Summary is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

### Q-2 Who is eligible for an HSA?

Only individuals who satisfy the following conditions on the first day of the month are eligible for an HSA offered under this Plan for that month:

- (a) You are covered under a qualifying High Deductible Health Plan (HDHP) maintained by your Employer that is identified as a benefit plan option in the Plan Information Summary;
- (b) You have opened an HSA with the Custodian chosen by the Employer;
- (c) You are not covered under any other non-high deductible health plan maintained by the Employer that is determined by the Employer to offer disqualifying health coverage [Note that you are not eligible for an HSA if you are covered under any non-qualifying coverage whether maintained by the Employer or not (including but not limited to coverage maintained by your spouse’s employer) and it is solely your responsibility to ensure that any other coverage you have that is not maintained by the Employer qualifies under Code Section 223] and
- (d) You cannot be claimed as a tax dependent by anyone else;
- (e) You are not enrolled in Medicare coverage; and
- (f) You are otherwise eligible for this Plan.

### Q-3 Who is an Account Beneficiary?

An Account Beneficiary is an eligible Participant who has properly enrolled in an HSA in accordance with the terms of the applicable Custodial Agreement.

### Q-4 Who is a Custodian or Trustee?

The Custodian or Trustee is the entity with whom the Account Beneficiary’s HSA is established (for purposes of this Plan, use of the term “Custodian” includes a reference to both Custodian and Trustee). The HSA is not sponsored by or maintained by the Employer. The Custodian or its designee will provide each Account Beneficiary with a Custodial Agreement and other information that describes how to enroll in the HSA and your rights and obligations under the HSA. The Employer may choose to restrict contributions made through this Plan to HSAs maintained by a particular Custodian; however, you will be permitted to rollover funds from the HSA offered under this Plan to another HSA of your choosing (in accordance with the terms of the Custodial Agreement).

### Q-5 What are the rules regarding contributions made to an HSA under the Plan?

Contributions made under this Plan may consist of both employee pre-tax contributions made pursuant to a Salary Reduction Agreement and/or non-elective Employer contributions (if any). You may elect to contribute any amount to the HSA that you wish; however, the maximum amount of all contributions that can be made to the HSA through this Plan (including both Employer non-elective and pre-tax salary reductions) during the Plan Year cannot exceed the maximum amount set forth in Code Section 223(b)(2) (as adjusted for inflation)

If the Account Beneficiary is age 55 or older and the Account Beneficiary properly certifies his or her age to the Employer, the maximum contribution amount described above may be increased by the “additional annual contribution” amount (as set forth in Code Section 223(b) (3)), but only to the extent set forth in the separate written HSA material provided by the Employer and/or the Custodian.

To the extent set forth in the Plan’s enrollment material or the HSA communication material, the Employer may automatically withhold pre-tax contributions from your compensation to contribute to an HSA unless you affirmatively indicate that you do not wish to contribute to the HSA with pre-tax contributions. Pre-tax

## Premium Reduction Option

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contributions will equal the maximum annual contribution amount set forth above (reduced by any Employer non-elective contributions) divided by the number of pay periods remaining during the Plan Year. Non-elective Employer contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer) and communicated in Plan or HSA enrollment materials.

Your HSA election under this Plan will not be effective until the later of the date that you make your election or the date that you establish your HSA. Employer may adjust contributions made under this Plan as necessary to ensure the maximum contribution amount is not exceeded.

Any pre-tax contributions that cannot be made to the HSA because you have been determined to be ineligible for such contribution will be returned to you as taxable compensation or as otherwise set forth in the Plan enrollment material. Any non-elective contributions that cannot be made to the HSA because the employee is not eligible for such contribution will be returned to the Employer except as otherwise set forth in the applicable communication material.

### **Q-6 What are the election change rules under this Plan for HSA elections?**

You may change your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or its designee). Your election change will be prospectively effective as of the first day of the next pay period following the day that you properly submit your election change (or such later date as uniformly applied by the Plan Administrator to accommodate payroll changes). Your ability to make pre-tax contributions under this Plan to the HSA ends on the date that you cease to meet the eligibility requirements under this Plan.

### **Q-7 Where Can I get More Information on My HSA and its Related Tax Consequences?**

For details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA Custodial Agreement and/or the HSA communication material provided by your Employer.

## **Part 5. ERISA Rights**

This Plan is not a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). However, certain component benefits may be governed by ERISA. ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and Benefits
  - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
  - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
2. Continue Group Health Plan Coverage
  - You may continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your eligible dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
  - Obtain reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable

coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you requested continuation coverage), before losing coverage (if you requested continuation coverage), or up to 24 months after losing coverage (if you requested continuation coverage). Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries

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

4. Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

5. Assistance with Your Questions

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

## Part 6. Plan Information Summary

### 1. Employer Organization

Name of Organization: Holton Public Schools  
 Federal Employer ID Number: 38-6002938  
 Mailing Address: P.O. Box 159  
 City, State, Zip: Holton, MI 49425  
 Street Address: P.O. Box 159  
 Street Zip: 49425  
 Form of Organization: Non-Profit  
 Organized in the state of: MI

Employer Affiliates:

### 2. Plan Elections

Plan Number: 501  
 Plan Name: Holton Public Schools Cafeteria Plan  
 Original Effective Date: 07/01/2006  
 Plan Year Runs\*: 01/01 - 12/31  
 Plan Restated and Amended: 01/01/2010

\*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

**Plan Administrator:** Holton Public Schools  
**Plan Service Provider:** BASIC  
 Street Address: 9246 Portage Industrial Drive  
 City, State, Zip: Portage, MI 49024  
 Phone: (269) 327-1922

### Benefits Coordinator

Name: Kathleen Hamilton  
 Phone: (231) 821-1703  
 Company Name: Holton Public Schools  
 Street Address: P.O. Box 159  
 City, State, Zip: Holton, MI 49425

### Acceptance of Legal Process

Name: Ann M. Cardon  
 Phone: (231) 821-1703  
 Company Name: Holton Public Schools  
 Street Address: P.O. Box 159  
 City, State, Zip: Holton, MI 49425

The appointed Plan Service Provider in conjunction with the Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

**3. Eligibility Requirements**

For the initial plan year and all subsequent plan years the eligibility requirement(s) is the following:  
Eligibility is based on health plan.

**4. Plan Entry Date**

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is the later of the date the Employee files a Salary Reduction Agreement during the applicable Enrollment Period or Date requirements are met.

**5. Benefit Package Options offered under this Plan**

Core Medical Plans.

The terms, conditions, and limitations of the Core Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies.

**6. Incorporated By Reference**

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.