# THE SECOND RESTATED
# MECOSTA-OSCEOLA INTERMEDIATE SCHOOL DISTRICT
# CAFETERIA PLAN

## SUMMARY PLAN DESCRIPTION

## TO OUR EMPLOYEES

This document is called a Summary Plan Description. Its purpose is to explain the provisions of the Second Restated Mecosta-Osceola Intermediate School District Cafeteria Plan.

**The Plan was originally effective as of March 1, 1996. It was amended and restated as of September 1, 2003. The Effective Date of the Restated Plan is July 1, 2020.**

You are urged to read this Summary Plan Description carefully. It does not replace the provisions of the Plan documents. The Plan documents govern the operation of the Plan. However, we have tried to make this Summary Plan Description complete and accurate without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan documents, the terms of the Plan documents will prevail.

The existence of this Plan does not grant employees any legal right to continue employment with the Employer or affect the Employer's right to separate employees from employment.

Mecosta-Osceola Intermediate School District

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**SUMMARY PLAN DESCRIPTION**

## I. PLAN OVERVIEW

Under the Second Restated Mecosta-Osceola Intermediate School District Cafeteria Plan (the "Plan"), you will have the opportunity on an annual basis to elect to participate in a number of qualified non-taxable Benefits. The cost of the benefits that you select may be paid by reducing your salary each pay period and contributing the funds derived from that reduction of salary to accounts maintained under the Plan. Finally, the Plan allows you to elect to waive participation in the major medical insurance plan sponsored by the Employer, and to receive a taxable cash benefit instead.

## II. PARTICIPATION

If you are an Employee of the Mecosta-Osceola Intermediate School District, who is or will be eligible to participate in the Employer's health insurance plan, and you have filed or will file the appropriate election forms with the Administrator during an Election Period under the Plan, you will become a Participant under the Plan. If you are not currently eligible to participate in the Plan, you may become a Participant on the first day of the month following the date you become eligible for coverage under the Employer's health insurance plan, provided you file appropriate election forms with the Administrator before the date that you are supposed to begin participating.

If you are an Employee who is a member of a bargaining unit with a Collective Bargaining Agreement with the Employer, you will begin to participate at the time mandated by the Collective Bargaining Agreement, provided that you have met all other requirements for participation stated in the Collective Bargaining Agreement, if any.

If as of July 1, 2020, you were participating in any of the Benefits offered under the Plan before it was restated, your participation in those Benefits that you selected will continue for the remainder of the Plan Year applicable to your employee group describe in Section XII.H in accordance with the Election form that you submitted to the Administrator for the Plan Year.

Going forward, your participation in the Plan will terminate if you separate from service with the Employer, no longer satisfy the eligibility requirements for participation (e.g. you no longer satisfy the conditions for participation in the Employer's medical insurance plan), do not file election forms on a timely basis, or the Plan is terminated.

## III. BENEFITS THAT YOU MAY SELECT

The "Election Period" shall be the period during the calendar month before the first day of each Plan Year as designated by the Administrator, or such other period as the Administrator reasonably designates. The first day of each new Plan Year for Eligible Employees other than Employees who are members of the Michigan Education Association bargaining unit is July 1 and

January 1 for Eligible Employees who are members of the Michigan Education Association bargaining unit. If you become eligible to participate in the Plan on a date that is not within the Election Period, you will be permitted to submit election forms during the thirty (30) calendar day period immediately before the date that your participation under the Plan is supposed to begin.

The following paragraphs generally describe the benefits available to you under the Plan:

**Medical Insurance**

Unless you waive medical insurance coverage, you will receive coverage under the Policy or Policies maintained by the Employer to provide medical coverage as you have designated in the appropriate election form. Coverage will be provided to you in accordance with the pertinent provisions of the Collective Bargaining Agreement between the Employer and the bargaining unit that represents you or, if you are not a member of a bargaining unit, in accordance with the terms of your employment with the Employer.

**Medical Insurance Premium, Employee Portion**.

The Employer will offer you coverage under the Employer's health insurance plan. Under the terms of your employment with the Employer, you may be responsible to contribute a portion of the Premium for the coverage that you elect. By selecting this benefit, your compensation each pay period will be reduced under a Salary Reduction Agreement to pay your contribution in the amount which, when added to the Employer's portion, is required for the Premium for the coverage that you designate in your benefit election form. Funds derived in this manner will be credited to your Medical Insurance Premium Account. Premiums will be paid from your Medical Insurance Premium Account as required by the terms of the Employer's health insurance plan. Amounts credited to your Medical Insurance Premium Account may only be used to pay medical insurance Premiums, and any amount credited to your Account within a Plan Year that is not used for that purpose before the end of that Plan Year will be deemed forfeited.

**Waiver of Medical Insurance; Cash Option**

This gives you the option of waiving your participation in the major medical insurance coverage offered by the Employer and receiving a cash benefit in lieu of coverage. This benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you.

Under the procedures effective for this Benefit as of the date of this Summary Plan Description, you may elect to not receive coverage under the major medical insurance plan maintained by the Employer for a Plan Year by merely executing a the Waiver form provided by the Administrator within the relevant Election Period and receive cash in lieu of medical insurance coverage. In addition, you must provide "reasonable evidence," in a form and manner determined by the Plan Administrator, that you have or will have minimum essential coverage as defined under the Affordable Care Act (other than coverage in the individual market, whether or not obtained through the Marketplace) during the Plan Year to which your waiver applies.

If you elect to waive coverage under the Employer's insured medical plan you will receive cash in lieu of health insurance coverage in an amount and at the times determined by referencing

the pertinent provisions of the Collective Bargaining Agreement between the Employer and the bargaining unit that represents you, or if you are not part of a bargaining unit, the terms of the your employment with the Employer. Unless otherwise provided, your waiver of health insurance shall apply to major medical coverage for which you are eligible and shall not apply to other insured benefits such as dental or vision coverage.

Notwithstanding the foregoing, this Benefit may not be offered to a Participant who is eligible for coverage by Medicare or Tricare, unless the Participant provides satisfactory proof of primary medical coverage consistent with the conditions described in the preceding paragraph (and other than by Medicare or Tricare), such as under a group health plan sponsored by the Employer of the Participant's spouse. In addition, this Benefit is not available to Participants who are covered by Medicaid or VA health care.

Contact the Plan Administrator if you have any question about these rules.

**Health Savings Account Contributions**

You may have the option of participating in a Health Savings Account (HSA) Contribution benefit that allows you to contribute money to your HSA on a pre-tax basis. This benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you. In order to participate in this benefit, you must be eligible to participate in, and you must enroll in, an HSA. To be HSA-eligible you must be enrolled in the high deductible health plan sponsored by the Employer, but you may not be covered by any other medical insurance, other than permitted coverage. So, for example, you cannot contribute to an HSA if you are participating in the Medical Expense Reimbursement Plan on a "general purpose" basis, even if you are also participating in the high deductible health plan; however you may participate in the Medical Expense Reimbursement Plan on a "limited purpose" basis. See the Administrator if you have any question regarding your HSA eligibility.

Subject the terms and conditions described in this paragraph, the Employer will accelerate amounts that you elect as elective contributions (pursuant to the your Salary Reduction Agreement) into your HSA, in an amount determined by the Employer, but not more than the maximum amount that you elect. If the Employer accelerates contributions as to any Plan Participant, then the Employer must offer accelerated contributions to all HSA Participants on the same terms and conditions. The terms and conditions upon which the Employer may make accelerated contributions include (without limitation):

(i) The Employer will not be required to make an accelerated contribution on your behalf more than one time per Plan Year: generally, on or about the first day of the Plan Year.

(ii) The Employer will not be obligated to make any additional accelerated contribution into your HSA during a Plan Year in which the Employer previously made an accelerated contribution, even if you modify your HSA election during the Plan Year to increase the amount of your HSA contribution.

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

(iv) You must repay the entire amount of the accelerated contribution by the end of the Plan Year through the pre-tax salary reduction. You must agree that if you do not repay the Employer for the entire amount of the accelerated contribution by the end of the Plan Year, then the Employer may withhold and recoup the deficiency from compensation due and owing to you from the Employer, or which becomes due and owing to you from the Employer in the future (including but not limited to amounts that become payable in a final paycheck on separation from employment); provided that such withholding shall not violate any applicable state or federal law, such as wage and hour laws. If, however, you do not have sufficient compensation to repay the entire amount of a deficiency, then you will remain liable to the Employer in the amount of the deficiency, and the Employer reserves the right in its sole discretion to use any legal means that the Employer deems appropriate to collect the unpaid deficiency (plus interest and attorney fees), which may include the commencement of judicial collection proceedings.

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

(vi) Before the Employer will accelerate any contributions into your HSA, you must execute an agreement incorporating the terms and conditions set forth herein, and such other terms and conditions the Administrator reasonably requires.

Please note that the provisions of the Plan pertaining to permitted changes to benefit elections (explained in Section V of this Summary Plan Description) do not apply to salary reductions made for purposes of contributing to an HSA. Consequently, you may revoke or modify a salary reduction agreement to fund an HSA, prospectively, at any time during a Plan Year.

Your HSA is not an Employer-sponsored employee benefit plan. In order to elect HSA benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax salary reductions through the Employer's payroll system to your designated HSA trustee/custodian. The Employer does not maintain or administer your HSA. However, the Administrator will maintain records of HSA contributions sent to your HSA trustee/custodian through the Plan.

You should refer to the documentation provided to you by your HSA trustee/custodian for information regarding the operation of your HSA, including how medical expenses are paid from your HSA and how those distributions are treated for tax purposes.

The Plan Administrator may establish rules and a procedure for the election of salary reductions by Participant's to fund HSAs that are reasonably and practicably consistent with the provisions of this Plan, and in compliance with applicable laws, regulations and published guidance.

To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other

penalties), see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

**Medical Expense Reimbursement Plan**

You may have the option of participating in a health care flexible spending account plan that allows you to pay uninsured medical care expenses using pre-tax dollars. This benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you. When you elect this benefit, your compensation will be reduced in accordance with a Salary Reduction Agreement that you enter into with the Employer, and amounts derived from the reduction of your salary will be credited to a Health Care Reimbursement Account established on your behalf by the Administrator under the Medical Expense Reimbursement Plan. If you choose to participate in this Benefit, you may set aside pre-tax money to pay Eligible Medical Expense that you, your spouse and dependents incur during the Plan Year. The maximum amount that you can set aside is adjusted by the IRS periodically for cost-of-living. The Employer will tell you the maximum amount that you may set aside in your annual Benefit election packet. You must make your election during the Election Period before the first day of the Plan Year for which the election is being made.

You may also be reimbursed for otherwise-eligible medical expenses incurred on behalf of a child through December 31 of the calendar year in which the child turns age 26, regardless of the child's residency, employment, financial dependence, student status, marital status, or status as a tax dependent.

Because of Internal Revenue Service rules, it is important that you estimate your annual medical expenses carefully before choosing the amount that you should put into your Health Care Reimbursement Account. Under current law, amounts that you put into your Health Care Reimbursement Account, but that you do not use for the reimbursement of eligible health care expenses by the end of the time period for the filing of claims for the Plan Year (described in Section VII, below), are deemed forfeited and are lost forever.

An eligible expense is an expense paid for care as described in Section 213 (d) of the Internal Revenue Code. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses,"

**Limited Purpose Medical Expense Reimbursement Plan**

You may be eligible to participate in a high deductible health plan provided by the Employer and a health savings account program. Under applicable federal laws and regulations, with certain exceptions, participants in high deductible health plans may not participate in any other health plans. The Medical Expense Reimbursement Plan described in the preceding section is an "other health plan"; and, if you participate in the Medical Expense Reimbursement Plan on a "general purpose" basis, you are not eligible to participate in a health savings account.

An exception to this rule is participation in a flexible spending account plan which provides reimbursement for limited types of medical expenses, such as dental and vision care, and/or reimbursement for all types of eligible medical expenses after the minimum deductible under your high deductible health plan has been satisfied.

Consequently, the Employer has included features in the Medical Expense Reimbursement Plan that allows Employees who participate in the Employer's high deductible health plan and health savings account program to elect to participate in the Plan on a "limited purpose" basis, meaning that they may reduce salary for the purpose of paying Eligible Medical Expenses permitted under Internal Revenue Code Section 223 using pre-tax dollars, including vision and dental expenses. In addition, after the minimum deductible under the high deductible health plan is satisfied, all Eligible Medical Expenses subsequently incurred may be reimbursed to the extent of the Benefit elected by the Participant.

Again, if you do not participate in a high deductible health plan and a health savings account, you may participate in the Medical Expense Reimbursement Plan on a "general purpose" basis. You cannot participate in both a general purpose and the limited purpose health care flexible spending account plans. If you choose to participate in this Benefit on a "limited purpose" basis, you may set aside an amount of money for each Plan Year to pay for Eligible Medical Expenses on a pre-tax basis, up to the adjusted annual limit.

**Dependent Care Reimbursement Plan**

You may have the option of participating in a dependent care reimbursement plan that allows you to pay certain dependent cares expenses using pre-tax dollars. This Benefit may not be available to all groups of Employees, so check with the Administrator to see if it applies to you. When you select this Benefit, you may set aside pre-tax dollars to pay for qualifying dependent care expenses, which can include, for example, care for your children or your disabled spouse or parent. Your compensation will be reduced under a Salary Reduction Agreement that you enter into with the Employer, in an amount that you chose. Amounts derived from the reduction of your salary will be credited to a Dependent Care Reimbursement Account that the Administrator will establish under the Dependent Care Reimbursement Plan on your behalf. As you incur eligible dependent care expenses, you can request reimbursement for those expenses with pre-tax dollars from your Dependent Care Reimbursement Account.

If you choose to participate in this Benefit, you may set aside an amount of money for each Plan Year described below. You must make your election during the Election Period before the first day of the Plan Year for which the election is being made.

Dependent care expenses are eligible for reimbursement if they are necessary to enable you to work (or you and your spouse to work, if you are married). If your spouse is not employed outside the home, your dependent care expenses will not be eligible for reimbursement under the Plan, unless your spouse is a full-time student or physically or mentally incapable of self-care.

Each year that you participate in this benefit, you will designate the amount that you want deducted from your salary for that year. Subject to the dollar limitation described in the next paragraph, you may choose to reduce your salary for this purpose up to $5,000 ($2,500 per year if you are married and filing separately). The amount that you choose will be divided and deducted on a pre-tax basis from each of your paychecks throughout the year and credited to your Dependent Care Reimbursement Account.

Your contributions to your Dependent Care Reimbursement Account cannot exceed your annual earned income or that of your spouse, **whichever is less**. If your spouse is a full-time student or incapable of self-support, your spouse's annual income will be considered to be $3,000 ($250 per month), if you have one dependent, or $6,000 ($500 per month) if you have two or more dependents.

Because of Internal Revenue Service rules, it is important that you estimate your annual dependent care expenses carefully before choosing the amount that you should put into your Dependent Care Reimbursement Account. Under current law, amounts that you put into your Dependent Care Reimbursement Account, but that you do not use for the reimbursement of eligible dependent care expenses by the end of the time period for the filing of claims for the Plan Year (described in Section VII, below), are deemed forfeited and are lost forever.

You can be reimbursed for dependent care expenses incurred to care for an individual who qualifies as a dependent under the dependent care assistance plan. A "dependent" is either a "qualifying child" or a "qualifying relative." Generally, a "**qualifying child**" is: (a) a child (including stepchild, adopted child, or eligible foster child), or a sibling (or stepsibling) of the taxpayer, or a descendant of either; (b) has resided in the principal abode of the taxpayer for more than half of the relevant calendar year; (c) has not attained age 19 (or is a student who has not attained age 24 as of the end of the year); and (d) has not provided more than half of his or her support for that year. Generally, a "**qualifying relative**" is an individual who: (a) is a child (including stepchild, adopted child, or eligible foster child), a sibling (including stepsiblings), the taxpayer's father or mother or an ancestor of either of them, a stepparent, a niece or nephew, an aunt or uncle, certain in-laws of the taxpayer, or an individual, other than a spouse, who resides in the principal abode of the taxpayer and is a member of the household; (b) has gross income in the relevant calendar year not exceeding the exemption amount (Section 151(d) of the Code), or $3,650 for 2011 (this amount is subject to annual cost of living adjusted by the IRS); (c) receives more than half of his or her support for the year from the taxpayer; and (d) is not a qualifying child of any other taxpayer for the calendar year.

Examples of dependent care expenses that **are** eligible for reimbursement include charges from: a licensed and qualifying childcare center; a nursery school; in-home care for dependents unable to care for themselves; daytime summer camp; adult day care center; adult private sitter, nanny or home care companion.

Examples of expenses that **are not** eligible for reimbursement from your Dependent Care Reimbursement Account include: nursing home charges; overnight camp and schooling fees for children in the first grade and up; food and clothing expenses; payments to a spouse or to a person for whom you claim a dependent exemption on your federal income tax return; expenses you deduct or for which you take a tax credit on your federal income tax return.

The Dependent Care Reimbursement Account is just one way that you can attain a tax benefit for qualified dependent care expenses. The Internal Revenue Code also gives you a tax credit for qualified dependent care expenses when you file your income tax return. If your dependent care expenses are eligible for reimbursement from your Dependent Care Reimbursement Account, they also qualify for the federal government's dependent care tax credit. You can use both the Dependent Care Reimbursement Account and the federal tax credit, but you

cannot claim the same expenses for both. You may want to consult a tax specialist for advice on whether it would be most advantageous for you to use one or the other, or both of these tax benefits.

## IV. REDUCING YOUR PAY TO FUND BENEFITS

You will be given the opportunity to elect benefits for each Plan Year during the Election Period immediately preceding the Plan Year. The "Election Period" will occur at times designated by the Plan Administrator before the first day of each Plan Year, which is July 1 for all Eligible Employees other than Employees who are members of the Michigan Education Association bargaining unit, and January 1 for Eligible Employees who are members of the Michigan Education Association bargaining unit. If you become eligible to participate in the Plan on a date that is not within the Election Period, you will be permitted to make benefit selections during the thirty (30) calendar day period immediately preceding the date that your participation under the Plan is supposed to begin.

If, under the terms of your employment, you are eligible for Benefits under the Employer's medical insurance program, you will automatically participate in the Employer's medical insurance program. Also, under the terms of your employment, during the Election Period, you may be able to waive participation in the Employer's medical insurance program by signing a Waiver form provided by the Administrator, and receive cash, in lieu of health coverage, in the amount and at the times specified under the terms of your employment, such as in the Collective Bargaining Agreement covering your bargaining unit (if you are a member of a bargaining unit). Please refer to the Collective Bargaining Agreement for your bargaining unit, or if you are not a member of a bargaining unit, the source of the terms of your employment, for any conditions that you must satisfy in order to waive medical insurance coverage, as well as the amount and the timing of cash payments that you are entitled to receive by waiving participation in the Employer's medical insurance plan. You will need to provide the Administrator with a properly executed waiver and evidence of other insurance if do not want to participate in the Employer's health insurance plan.

When you complete your Salary Reduction Agreement, you can specify the amount of HSA Contributions that you wish to pay for with your salary reduction (provided that you are HSA-eligible). From then on, you make contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

During the Election Period, you will need to indicate whether you want to participate in one or more of the Employer's flexible spending account plans. Of course, you can choose not to participate in either of them. If you choose to participate in one or more of those benefits you must designate the amounts that you want to contribute to each, within the applicable dollar limits.

As an Eligible Employee, you will have the opportunity to select benefits under the Plan once each year during the Election Period. To continue participating in the Plan, you must complete a benefit election form during the Election Period. If you do not complete a benefit election form during the Election Period, you will not be eligible for benefits under the Plan during the ensuing Plan Year.

The sum of the amounts that you choose to contribute to the benefits under the Plan will be the total amount by which your salary must be reduced for the Plan Year in order to fund those benefits on a **pre-tax basis**. You will need to complete a Salary Reduction Agreement during the Election Period if you want the Employer to reduce your compensation to provide the Benefits that you have chosen with pre-tax dollars.

The amount of the reduction in your compensation may be changed by the Administrator, in its sole discretion, for the purpose of complying with applicable rules against discrimination, and as permitted under rules described below in Section V. In addition, the Administrator may make reasonable adjustments in reductions to your compensation if you have elected to receive fewer paychecks than the full-year's pay schedule (i.e., you do not receive paychecks during the summer months).

## V. CHANGING YOUR ELECTIONS

As a rule, a Benefit election that you make under the Plan may not be revoked after the beginning of the Plan Year for which the election applies. However, you may revoke a Benefit election before the end of the Plan Year for which the election applies in certain circumstances. Absent one of these circumstances, the election you make during an Election Period will stay in force for the entire Plan Year for which it was made. Of course, you can always change your election during a subsequent Election Period. **Please note that these rules do not apply to elections to make contributions to your HSA, and you may revoke your HSA election and make a new election at any time during the Plan Year.**

Notwithstanding the general rule, you may revoke an election under the Plan during a Plan Year for which the election was made, and prospectively make a new election for the remainder of the Plan Year, **under specific circumstances**. A request for an election change must be made in the form and manner prescribed by the Administrator. The Administrator may request additional information in support of the requested change. The change in your Benefit election, if approved by the Administrator, will be effective for pay periods beginning after the date the change is approved.

The following paragraphs generally describe the specific circumstances under which elections may be changed during a Plan Year:

A. Change in Status. You may revoke an election for **accident and health coverage or group-term life insurance coverage**, if provided under the Plan, and make a new election for the remaining portion of the Plan Year if you (i) have a "change in status"; and (ii) your election change is consistent with the particular change in status.

The following events are "changes in status" that may permit you to make a change in election:

1. Events that change your legal marital status, including marriage, death of a spouse, divorce, legal separation, or annulment.

2. Events that change the number of your dependents, including by reason of birth, adoption, placement for adoption, or death of a dependent.

3. Events that change your employment status or that of your spouse or your dependent, such as a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite.

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

5. A change in your place of residence or that of your spouse or your dependent.

Generally, a change of election is consistent with a change in status event only if the election change is on account of and corresponds with the change in status.

With respect to other qualified benefits (i.e., other than accident and health coverage or group-term life insurance), you may make a change of election if the election change is on account of and corresponds with a change in status **that affects eligibility for coverage** under the specific Benefit. In addition, you may make a change in election under a dependent care assistance benefit or adoption assistance benefit (if such Benefits are provided under the Plan) that is on account of and corresponds with a **change in status that affects expenses** under the dependent care assistance benefit or adoption assistance benefit.

If you, or your spouse or a dependent become eligible for continuation coverage (COBRA) under a group health plan of the Employer, you may increase payments under the Plan in order to pay for the continuation coverage.

B. Judgment, Decree, or Order. If you become subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your child or for a foster child that is your dependent, the Plan will change your election under the Plan if doing so is necessary for the required coverage to be provided in compliance with the judgment, decree or order. Further, if you present an order to the Plan Administrator that requires that coverage for a child be provided by your spouse, former spouse, or other individual, and you certify to the Plan Administrator that the required coverage is, in fact, being provided, then you may make an election change to cancel coverage for the child under the Plan.

C. Entitlement to Medicare or Medicaid. You may make a prospective election change to cancel or reduce accident or health Benefits under this Plan, if any, if you, your spouse, or a dependent become eligible for coverage under Medicare or Medicaid. You may make a prospective election to commence or increase accident or health Benefit coverage under the Plan if you or your spouse or a dependent who has been entitled to coverage under Medicare or Medicaid, losses eligibility for coverage.

D. Significant Changes in Cost or Coverage.

1. General. You may prospectively amend or revoke an election under this Plan for changes in cost or coverage as described below. **These provisions do not apply to health care flexible spending accounts (or on account of a change in cost or coverage under health care flexible spending accounts) which includes the Medical Expense Reimbursement Plan**.

2. Cost Changes.

a. Automatic changes. If the cost of a Benefit to which you contribute through salary reductions, increases (or decreases), the Plan Administrator will, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the amount of your salary reductions for that Benefit. For example, if you pay a portion of the cost of your health insurance through a salary reduction agreement under the Plan, and the premiums for your coverage increase during a Plan Year thereby causing your required contributions to increase, the Plan Administrator may automatically increase the amount of your salary reduction from future pay checks by an amount that corresponds to the increase in your required contribution.

b. Significant Cost Changes. If the cost of a Benefit to which you contribute through salary reduction significantly increases or significantly decreases during a Plan Year, you may make a **corresponding change** in your election under the Plan, such as by commencing participation in the Plan for a Benefit that has decreased in cost or, in the case of an increase in cost, revoking an election for that coverage and instead either receiving on a prospective basis coverage under another Benefit providing similar coverage or dropping coverage if no other Benefit providing similar coverage is available.

c. Application to Dependent Care. If you participate in a dependent care assistance flexible spending account under the Plan, you may change a benefit election for an increase or a decrease in cost **only if the cost change is imposed by a dependent care provider who is not related to you.**

3. Coverage Changes.

a. Significant Curtailment Without Loss of Coverage. If you or your spouse or dependent have a significant curtailment of coverage under a Benefit during a Plan Year, but there was not a loss of coverage (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit under an accident or health plan), you may revoke your election for that coverage and instead elect to receive on a prospective basis coverage under another Benefit providing "similar coverage," if another Benefit providing similar coverage is available under the Plan. Coverage under a Benefit is significantly curtailed only if there is an overall reduction in coverage provided under the Benefit so as to constitute reduced coverage generally. Therefore, for example, the elimination of one of your physicians from a network of providers under an accident or health plan would generally not constitute a significant curtailment.

b. Significant Curtailment With Loss of Coverage. If you or your spouse or dependent have a significant curtailment that results in a loss of coverage, you may

revoke your election for that coverage and instead elect to either receive on a prospective basis coverage under another Benefit providing "similar coverage," or drop coverage if no similar Benefit is available under the Plan. For purposes of this Plan, a "loss of coverage" means a complete loss of coverage under the Benefit or other coverage option.

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

4. Change in Coverage Under Another Employer Plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or of another employer) if (i) the other plan permits participants to make an election change that would be permitted under this Plan, or (ii) the Plan Year of the Plan is different than the Plan Year under the other plan.

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

E. Special Requirements relating to the Family and Medical Leave Act. If you take a leave of absence under the Family and Medical Leave Act (FMLA), you may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA.

F. Special Enrollment Rights. You may revoke an election for accident and health coverage and make a new election that corresponds with the special enrollment rights provided in Section 9801(f) of the Code (HIPAA). For example, the adoption of a child satisfies the conditions for special enrollment under Section 9801(f), which may permit you to enroll in family coverage under the District's health insurance plan. If you pay a portion of your health insurance cost through salary reduction under the Plan, and if enrolling in family coverage upon the adoption of a child results in an increase in the cost of your coverage, then you may increase your salary reduction in order to cover the increased cost.

G. Revocation due to reduction in hours of service. You may revoke an election of coverage under a group health plan if your expected hours of service change from at least 30/week to less than 30/week, even if the change does not result in you ceasing to be eligible under the group health plan. The revocation of the election of coverage must correspond to your enrollment 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.

H. Revocation due to enrollment in a Qualified Health Plan. You may revoke an election of coverage under a group health plan if you are eligible to enroll in a Qualified Health Plan through a Marketplace/Exchange, either in a Special Enrollment Period or in the regular Open Enrollment Period in the Marketplace. The revocation of the election of coverage must correspond to your enrollment 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.

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

## VI. LOSING BENEFITS UNDER THE PLAN

The Plan will provide you with Benefits during each Plan Year that you participate. You participate by electing benefits and reducing your salary to fund benefits. Benefits will be provided under the terms of the Plan, and the other plans and insurance policies maintained by the Employer to provide benefits under the Plan.

Circumstances may arise which will prevent you from receiving benefits or which will cause a cessation of benefits under the Plan. These include you becoming ineligible to participate in the Plan, for example by reason of employment termination or a change in employment status that results in you not meeting the requirements for participation. No benefits will be paid to you under the Plan for services rendered after the date that you become ineligible to participate.

## VII. BENEFIT CLAIMS PROCEDURES

Insured benefits provided in conjunction with this Plan (such as the Employer's major medical insurance plan) will have their own claims procedures. You should refer to the policies and related documents for the claims procedures under those insured plans.

The Plan provides a claims procedure that is relevant to the non-insured Benefits offered under the Plan. The Administrator will provide you with the required forms and instructions for submitting claims. Be aware that under the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan, you may submit claims for Eligible Expenses incurred during a Plan Year through the end of the first calendar month after the end of the Plan Year, and those claims will be paid to the extent you have sufficient account balances available as of the end of the Plan Year.

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

You, your beneficiary (where appropriate), or a duly authorized representative of a claimant may appeal the denial of a claim for Benefits by submitting a written request for a full and fair review to the Administrator. You may examine pertinent documents and submit pertinent issues and comments in writing. You may have a representative (who may be a representative of your bargaining unit if you are covered by a collective bargaining agreement) throughout the appeals process. Your written request for a review must be submitted within 60 days of the written notice of denial of the claim. The full and fair review will be completed and a decision rendered by the Administrator within 60 days after receipt of the written request for review. The time for rendering a decision may be extended by written notice, if warranted by special circumstances, for up to 60 days from the date of the receipt of the written request for review. The Administrator's decision will be in writing and will include specific reasons for the decision, with specific references to the Plan provisions on which the decision is based. The decision of the Administrator will be final and binding. The appeal procedure in the Plan is not intended to limit other remedies that may be available to you under applicable statutes, common law or equity.

## VIII. PAYMENT OF BENEFITS

All benefits payable under the Plan will be paid within a reasonable time after the Administrator approves your claims. If the amount of a claim exceeds the amount then available to pay the claim, the amount that is then available in the Account will be paid, and the excess claim will be held in suspense and paid later, provided that amounts sufficient to pay the excess are credited to your Account for that Plan Year.

Amounts payable under insurance policies maintained by the Employer to provide benefits under the Plan will be paid according to the terms and conditions of the policies as established between the Employer and the Insurer. Amounts paid as your contribution to Premiums due on insurance policies will be paid from the general assets of the Employer.

## IX. CONTINUATION COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Federal law requires most private and governmental employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules generally apply to a Health Flexible Spending Account Plan (unless the Employer is considered a "small employer").

The Plan Administrator can tell you whether the Employer is subject to federal COBRA continuation rules (and thus subject to the following rules). The following paragraphs are intended to summarize your continuation rights under federal law. If federal law changes, the rights provided under the then-current applicable federal law will apply. To the extent that any greater rights are set forth herein, they shall not apply.

**When Coverage May Be Continued**

Only "Qualified Beneficiaries" are eligible to elect continuation coverage if they lose coverage as a result of a Qualifying Event. A "Qualified Beneficiary" is the Participant, covered Spouse and/or covered dependent child at the time of the qualifying event.

A Qualified Beneficiary has the right to continue coverage if he or she loses coverage (or should have lost coverage) as a result of certain qualifying events. The table below describes the qualifying events that may entitle a Qualified Beneficiary to continuation coverage:

| Type of Event | Covered Employee | Covered Spouse | Dependent |
|---|---|---|---|
| Covered Employee's termination of employment or reduction in hours of employment | √ | √ | √ |
| Divorce or Legal Separation | | √ | |
| Child ceasing to be an eligible dependent | | | √ |
| Death of the Covered Employee | | √ | √ |

**NOTE:** Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

**Type of Continuation Coverage**

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. After electing COBRA coverage, you will be eligible to make a change in your benefit election with respect to the Health Flexible Spending Account Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year (See Section V of this Summary).

If you do not choose continuation coverage, your coverage under the Health Flexible Spending Account Plan will end with the date you would otherwise lose coverage.

**Notice Requirements**

You or your covered Dependents (including your Spouse) must notify the Plan Administrator in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of (i) date of the event (ii) the date on which coverage is lost because of the event. Your written notice must identify the qualifying event, the date of the qualifying event and the qualified beneficiaries impacted by the qualifying event. When the COBRA Administrator is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's Spouse is treated as notice to any covered Dependents who reside with the Spouse. You may be required to provide additional information/documentation to support that a particular qualifying event has occurred (e.g. divorce decree).

An employee or covered Dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan.

**Election Procedures and Deadlines**

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) and return it to the Plan Administrator within 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

**Cost of COBRA Coverage**

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first contribution after electing continuation coverage will be due 45 days after you make your election. Subsequent contributions are due the 1st day of each month; however, you have a 30-day grace period following the due date in which to make your contribution. Failure to make contributions within this time period will result in automatic termination of your continuation coverage.

**When Continuation Coverage Ends**

The maximum period for which coverage may be continued is the end of the Plan Year in which the qualifying event occurs. However, in certain situations, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event and the level of Non-Elective contributions provided by the Employer). You will be notified of the applicable maximum duration of continuation coverage when you have a qualifying event. Regardless of the maximum period, continuation coverage may end earlier for any of the following reasons:

• if the contribution for your continuation coverage is not paid on time or it is

significantly insufficient (Note: if your payment is insufficient by the lesser of 10% of the required premium, or $50, you will be given 30 days to cure the shortfall);

• if you become covered under another group health plan and are not actually subject to a pre-existing condition exclusion limitation;

• if you become entitled to Medicare; or

• if the Employer no longer provides group health coverage to any of its employees.

## X. AMENDMENT AND TERMINATION OF THE PLAN

The Employer intends to maintain the Plan indefinitely. It may be necessary or desirable at times to amend the Plan, or to terminate the Plan. If you are a member of a collective bargaining unit, the Plan cannot be terminated, or amended in a way that affects your benefit levels or eligibility to participate, unless your bargaining unit consents to the termination or amendment. If, however, it becomes necessary to amend the Plan in order to keep it in technical compliance with applicable sections of the Internal Revenue Code or the Treasury Regulations, the Employer may make those amendments without the consent of your bargaining unit. However, the Employer will provide your bargaining unit with written notice of the amendment at least 30 days before the amendment is to become effective. No amendment or termination of the Plan will prevent the payment of benefits on proper claims incurred before the date of the amendment or termination, provided that you were eligible to participate through the date of the amendment or termination.

## XI. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS

1. General. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

2. Participant's Rights.

a. Right to Request Restrictions on Uses and Disclosures of Your PHI. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment,

payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your health care. However, the Plan is not required to agree to your request.

b. Right to Inspect and Copy Your PHI. You have a right to inspect and obtain a copy of your PHI contained in a "Designated Record Set," for as long as the Plan maintains the PHI. For purposes of the Plan, "Designated Record Set" includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. If you are denied access to your PHI by the Plan, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

c. Right to Request Amendments to Your PHI. You have the right to request the Plan to amend your PHI or a record about you in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

d. Right to Request an Accounting of Disclosures of Your PHI. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) prior to the compliance date. If the accounting cannot be provided within 60 days, the Plan is automatically entitled to take an additional 30 days to provide the accounting by giving you a written statement of the reasons for the delay and the date by which the accounting will be provided.

e. Right to Exercise Privacy Rights through Your Legally Authorized Representative. You may exercise your rights through a Legally Authorized Representative. Your Legally Authorized Representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Please note that the Plan at all times retains the discretion to deny a representative's access to your PHI if the Plan believe that giving access could subject you to abuse or neglect. This also applies to representatives of minors.

f. Right to Receive Notice of Privacy Rights. You have the right to be informed of the privacy practices of the Plan, as well as to be informed of your privacy rights with respect to your PHI. In addition to the explanation contained in this Summary Plan Description, the Plan has developed and has or will distribute a notice to you that provides a clear explanation of these rights and practices. The Plan must make its Notice available to you if you request it. In addition, the Plan must provide the notice to you: if you are covered by the Plan, at the time of your enrollment; provide a revised notice to you within 60 days of a material revision to the notice; and, notify you of the availability of and how to obtain the notice at least once every three years.

3. Complaints.

If you believe that your privacy rights have been violated or would like to request any of the information listed above, you may contact the Plan's Privacy Officer at the following address: 15760 190th Ave, Big Rapids, MI 49307.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

## XII. OTHER IMPORTANT INFORMATION

A. Plan Name. The Second Restated Mecosta-Osceola Intermediate School District Cafeteria Plan.

B. Name, Address and Telephone Number of the Employer:

Mecosta-Osceola Intermediate School District
15760 190th Ave
Big Rapids, MI 49307
Ph. (231) 796-3543

C. The Employer's Employer Identification Number: 38-1720900.

D. Type of Plan: Welfare Benefit Plan.

E. Name, Address and Telephone Number of the Plan Administrator:

Mecosta-Osceola Intermediate School District
15760 190th Ave
Big Rapids, MI 49307
Ph. (231) 796-3543

F. Plan Number: 511.

G. Name and Address of Agent for Service of Legal Process:

Steve Locke, Superintendent
Mecosta-Osceola Intermediate School District
15760 190th Ave
Big Rapids, MI 49307

H. Plan Year: As to all Eligible Employees other than Employees who are members of the Michigan Education Association bargaining unit, the Plan Year is the 12 month period beginning July 1 and ending the next succeeding June 30. As to Eligible Employees who are members of the Michigan Education Association bargaining unit, the Plan Year is the calendar year.

I. Effective Date of the Second Restated Plan: July 1, 2020

## XIII. FURTHER INFORMATION

Copies of the Plan and any ancillary insurance contracts are available at the offices of the Administrator.