Wexford-Missaukee Intermediate School District
Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

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This booklet contains a summary in English of your plan rights and benefits under the Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan. If you have difficulty understanding any part of this booklet, contact the benefits department of Wexford-Missaukee Intermediate School District at 9907 E. 13th Street, Cadillac MI 49601.

This is only a summary of the Benefit Plan. A copy of the Plan Document, containing more detail, is available from the Plan Administrator upon your request.

This Plan is established by the above named employer and is the only employer offering the benefits of the Plan.

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Plan Purpose

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan is a benefit program that allows you to use benefit dollars in a cost effective manner which best suits your needs. Section 125 of the Internal Revenue Code permits Wexford-Missaukee Intermediate School District, the Employer, to offer you the opportunity to get involved in designing your personalized benefit plan on a tax-favored (pretax) basis.

Who Is Eligible to Enroll in The Plan

You are eligible for this Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan if you meet the eligibility requirements set forth in this Flexible Benefit Plan. Part-Time employees who work less than 40 hrs/week are ineligible for this Plan. Employees with less than 3 months of employment are ineligible for this Plan. Retired employees are ineligible and former employees are ineligible.

How and When to Enroll

After you become eligible, you must select which benefits you would like to purchase by salary reduction through the Plan. Your decision must be made during the month preceding the Plan Year for which it will be in effect. If you are a newly hired employee, you must make your decision during the month immediately preceding your becoming eligible. Prior to each Plan Year the Employer will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your compensation reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent possible. If you are already a Plan Participant and you fail to complete an election form for the upcoming Plan year, then you will maintain the benefit options that you elected for the prior year, but will not be eligible to participate in the available Reimbursement accounts.

You may design a completely new plan each Plan Year. Keep in mind that your choices are in effect for the entire Plan Year. *Only under special circumstances,* such as a change in status, changes in the cost of coverage under the plan, and certain other events, may you apply to change your selected benefits. Generally, the change must be consistent with the change event; to the extent it is necessary or appropriate as a result of the change.

Special circumstances also include cost and coverage changes to a health plan, such as a significant increase in the cost of your coverage, a significant decrease in or cessation of your coverage or a significant change in your health coverage or your spouse’s attributable to your spouse’s employment. For these circumstances, however, only a change to another health plan with similar coverage is permitted. Think about your needs carefully because the benefits you choose but do not use cannot be converted to cash or accumulated from year to year.

Rules for change in benefits due to a Change in Status in accordance with the following:

A Participant may drop coverage if the cost of that coverage significantly increases and there is no similar alternative coverage available.

An Eligible Employee, who is not enrolled, or are enrolled in a similar benefit options may enroll in a coverage, when there has been a significant decrease in the cost of the desired coverage.

An Eligible Employee, who is not enrolled, or are enrolled in a similar benefit option, may enroll in a new coverage when a new benefit option is added or a benefit option is significantly improved.

When a significant coverage is no longer available resulting in a loss of coverage under this Plan, a Participant may change to another benefit option, if available, or cease enrollment.

Participants may make a change in benefit options that corresponds with changes made under a cafeteria plan of the spouse's or dependent's employer including changes made under the plan of the employee's employer. The change request must be combined with adequate documentation describing the change in coverage for which the Participant, dependent, or domestic partner is covered.

Participants may make a change in coverage to add self or dependent that lost coverage under a health plan maintained or administered by a government or educational institution.

Participants may make a change in coverage to add self or dependent that lost coverage under a Medicaid Plan or under a state children's health insurance program.

Participants may make a change in coverage to add self or dependent when becoming eligible for state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

Participants who were expected to average at least 30 hours of service per week may drop group health plan coverage midyear if the participant's status changes so that the Participant is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the change must correspond to the Participant's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped.

Participants who are eligible to enroll in Exchange coverage (during an Exchange special or open enrollment period) may drop group health coverage midyear, but only if the change corresponds to the Participant's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Exchange coverage that is effective no later than the last day of the original coverage.

A Participant entitled to make a new election must do so within **30** days of the event described above except for changes corresponding to Medicaid or a state children's health insurance program for which the request must be made within 60 days. Any such election shall apply for the balance of the Plan Year in which the election is made unless a subsequent event occurs.

Whenever a Participant in this Plan is making a change in benefit options due to a Change in Status, the Participant may also make changes in life, disability, and dismemberment (including accidental death and dismemberment) coverage even though eligibility for such coverage is not affected by the Change of Status event.

If you should terminate your employment and stop your elections under this Plan, you may, if rehired, begin to participate in the Plan again after re-satisfying the eligibility requirements. However, you may not make a new election, which is effective during the Plan Year in which your service with the Employer was terminated.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax contributions until the next Plan Year.

FMLA Leave.
A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

Schedule of Flexible Benefits

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the various benefit plan Reimbursement accounts are provided by the Employer on the Enrollment Form, and as shown on the attached Schedules A, B, and C.

The benefits from which you may choose include:

Medical Reimbursement Accounts Plan

Dependent Care Reimbursement Account Plan

Premium Conversion Plan

You may purchase the above coverage for yourself, (and in some cases for your qualified dependents), through the Flexible Benefits Plan. You may pay for these benefits using pretax dollars that are automatically deducted each designated pay period.

Medical Reimbursement Accounts

There are some expenses you know you will have to pay for in the coming year; for instance, new eyeglasses, medical and dental expenses not reimbursed by the health plan. Normally you would pay for expenses like these with after-tax income. And because taxes reduce the value of your dollars, you would have to earn considerably more than $100 to pay $100 of these expenses.

If you are eligible to participate, the Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan allows you to contribute pretax income to create a special reimbursement account in order to reimburse yourself on a pretax basis for payment of certain medical and other outlined expenses (See Schedule A). It's like getting a discount on these bills since you don't have to earn as much money to pay for them. The money you contribute to the reimbursement accounts by automatic payroll deduction is not subject to federal or Social Security taxes, but depending on your residence, may be subject to state and local income taxes.

How the Medical Reimbursement Account Works
You may establish a reimbursement account for predictable medical expenses, including dental and vision care expenses. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year and any applicable Grace Period, a portion of that amount may be paid for with pretax pay, deposited on a per pay period basis to the medical reimbursement account. The minimum and maximum pretax deferral allowed for the Medical Reimbursement Account during a Plan Year is shown on Schedule A. Once you have completed the Compensation Reduction Agreement for Medical Reimbursement Account, you may file a claim for the afore mentioned medical expenses incurred or paid on or after your entry date, and during the current Plan Year and subsequent Grace Period, if applicable, that have not been reimbursed under any other Employer's accident or health plan. Generally, the qualified expenses are costs you have paid or incurred that exceed any plan deductibles and co-payments, as determined as allowable medical expenses under IRS Code Section 213, and to the limit of your Benefit Credits. The Plan Administrator will inform you of the rules that apply to filing claims.

Under this category are expenses such as non-reimbursable medical expenses covered by any other Employer's accident and health plan. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed practitioner to qualify. Covered expenses *do not include* premiums paid for other health plan coverage, including plans maintained by the employer of a family member, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage.

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs because the tax laws only allow up to $500 of unused amounts in your medical reimbursement account to be to be carried over at the end of each Plan Year or a Grace Period of up to 2 ½ months, but not both and your plan may not have either option.

When you are reimbursed for these qualified expenses, your Medical Reimbursement Account will be debited in the amount of reimbursement, provided there are sufficient benefit credits available. Once you have elected the amount of your compensation reduction you may not add to or change the amount except as explained above as a result of a Change of Status. You may make a new election to change or eliminate the compensation reduction amounts at the beginning of each Plan Year. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

Expenses for orthodontia services are reimbursable before the services are provided but only to the extent that the employee has actually made the payments in advance of the orthodontia services in order to receive the services. These orthodontia services are deemed to be incurred when the employee makes the advance payment.

If your plan does not have a Carry Over or a Grace Period, compensation reduction amounts in the form of Benefit Credits remaining in your Reimbursement Account after all qualified claims have been filed and paid during a Plan, cannot be carried forward in any following year, and will be forfeited. It is therefore important that you carefully estimate your potential needs for the entire length of the Plan Year to assure that you have enough credits for your needs, but so as to have no un-used, remaining credits that you will lose.

The Wexford-Missaukee Intermediate School District Section 125 Cafeteria PlanWexford-Missaukee Intermediate School District Section 125 Cafeteria Plan does not allow a grace period and allows a carryover for the Medical Reimbursement Account Plan.

Since The plan allows for carryover, you may carry over up to $500 of benefits in your Medical Reimbursement Account to be used for qualifed medical expenses incurred during the following plan year. Any unused portion of Qualified Benefits in excess of $500 will be forfeited at the end of the period for filing claims for the Plan Year.

Medical Care Expenses incurred in the current Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses during the run-out period, cannot exceed $500, and will count against the $500 maximum carryover amount.

You may elect prior to the beginning of the next Plan Year to waive the carryover for that Plan Year in accordance with procedures established by the Plan Administrator.

Opt-Out for Health Savings Account (HSA) Coverage
During open enrollment or if a HIPAA Special Enrollment event occurs, a Participant may elect to opt-out a spouse and/or child(ren) from coverage under this Plan if the spouse and/or child(ren) are enrolled in a Qualifying High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). The Participant must complete a "Waiver of Coverage" form to opt-out a spouse and/or child (ren) from coverage under the Plan.

The spouse and/or child(ren) and Participant understand that by electing to opt-out of coverage under the Plan, the spouse and/or child(ren) will:

A. Not be entitled to any benefits or other payments from the Plan.

B. Have no right or claim to any contributions made to the Plan for the purposes of funding the spouse's and/or child(ren)'s eligibility for coverage.

C. Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the spouse's and/or child(ren)'s HDHP.

D. Have no right to return to coverage under the Plan until such time as the HDHP coverage is lost as allowed in section titled Events Permitting Exception to Irrevocability Rule, the Dependent otherwise meets the eligibility requirements of the Plan and provides written notice to the Plan Administrator of the desire to once again become covered by the Plan.

The "Waiver of Coverage" form can be obtained from the Plan Administrator. The participant must indicate the date upon which the waiver of coverage will be effective.

FSA Dependent Waiver of Coverage - Opt-Out for Health Savings Account (HSA) Coverage

During open enrollment or if a HIPAA Special Enrollment event occurs, a Participant may elect to opt-out a spouse and/or child(ren) from coverage under this Plan if the spouse and/or child(ren) are enrolled in a Qualifying High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). The Participant must complete a "Dependent Waiver of Coverage" form to opt-out a spouse and/or child(ren) from coverage under the Plan.

The spouse and/or child(ren) and Participant understand that by electing to opt-out of coverage under the Plan, the spouse and/or child(ren) will:

A. Not be entitled to any benefits or other payments from the Plan.

B. Have no right or claim to any contributions made to the Plan for the purposes of funding the spouse's and/or child(ren)'s eligibility for coverage.

C. Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the spouse's and/or child(ren)'s HDHP.

D. Have no right to return to coverage under the Plan until such time as the HDHP coverage is lost as allowed in section titled Events Permitting Exception to Irrevocability Rule, the Dependent otherwise meets the eligibility requirements of the Plan and provides written notice to the Plan Administrator of the desire to once again become covered by the Plan.

The "Waiver of Coverage" form can be obtained from the Plan Administrator. The participant must indicate the date upon which the waiver of coverage will be effective.

How the Dependent Care Reimbursement Account Works

In General.
You may also establish a reimbursement account for reimbursement for predictable qualified dependent care. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, portions of that amount may be paid for with pretax pay, deposited on a per bi-weekly pay period basis to the Dependent Care Reimbursement Account. The minimum amount you may defer as shown on Schedule B of this document. The maximum pretax deferral allowed for the Dependent Care Reimbursement Account during a Plan Year is $5,000. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended. Any Employer contribution to Dependent Care Account will be made prospectively and will be available for the entire Plan Year.

Eligible Expenses.
Eligible Expenses or Reimbursable Expenses are expenses payable by the Plan Administrator according to the definitions below. The term "Eligible Expense" means any reasonable expense incurred by the Participant or his Spouse for Qualifying Services for the cost of sending a child of the Participant to a Qualifying Day Care Center. The Employer shall determine in its sole discretion whether any expense is reasonable. An expense shall be an Eligible Expense only if it is payable to a person who is not either the dependent of the Participant, or the Participant's Spouse, or a child of the Participant under the age of 19 as of the close of the Plan Year in which the Qualified Services are rendered.

Definitions.

"Qualifying Day Care Center" means a day care center that provides full-time or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the Eligible Employee's taxable year, and which:

A. complies with all applicable laws and regulations of the state and town, city or village in which it is located; and

B. receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

"**Qualifying Individual**" means:

A. a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1);

B. a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or

C. a Spouse of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principle residence of the participant for more than one-half of the Plan Year.

D. In the case of divorced or separated parents, a Qualifying Individual who is a small child shall, as provided in Code § 21 (e)(5), shall be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

"Qualifying Services," means the following: services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed—

- in the Participant's home; or
- outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

E. *Exclusion.* Dependent Care Expenses do not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code §151(c) to a Participant or his or her Spouse;
- a Participant's Spouse;
- a Participant's child (as defined in Code §152(f)(1)) who is under l9 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's under age 13 qualifying child (as defined in Code §152(a)(1)).

"Services" means the duties performed to enable a Participant and his Spouse to remain gainfully employed and which are related to the care of a Qualifying Individual.

"Spouse" means the person to whom the Participant is legally married but shall not include an individual legally separated from a Participant under a decree of legal separation.

"Student" means an individual who during each of five calendar months during a Plan Year is enrolled as a full-time student at an Educational Institution.

If dependent care is required to enable you and a spouse (or a single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a non-relative, as long as such person is reporting payments as income, is also eligible. However, you must have accumulated a sufficient credit balance in your Dependent Care Reimbursement account in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as more dollars are contributed from your pay to your Dependent Care Reimbursement account.

To qualify for tax-free treatment, you will be required to file IRS Form 2441 (“Child and Dependent Care Expenses”) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names, addresses and taxpayer identification numbers (TIN) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If the caregiver is an individual, the TIN is the individual’s Social Security Number. No TIN is necessary for exempt organizations, only the name and address of the provider. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit.

Compensation reduction amounts in the form of Benefit Credits remaining in your Reimbursement Account after all qualified claims have been filed and paid during a Plan Year and subsequent Grace Period, if applicable, cannot be carried forward in any following year, and will be forfeited. It is therefore important that you carefully estimate your potential needs for the entire length of the Plan Year to assure that you have enough credits for your needs, but so as to have no un-used, remaining credits that you will lose.

The plan does not allow a grace period for the Dependent Care Reimbursement Account Plan.

Reimbursement accounts - Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible reimbursement accounts.

Compensation redirection authorized for both medical (and employer provided dependent care contributions, if available,) reimbursement is in effect for the entire year unless you have a change in family status ---such as marriage, divorce, death of a child or spouse, adoption or birth of a child, termination or commencement of your spouses' employment, the switching from part-time to full-time employment status or the reverse by you or your spouse or taking of an unpaid leave of absence by you or your spouse.

If your plan has a Grace Period, you must use all the funds in your reimbursement account by the end of the Plan Year and subsequent Grace Period, or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Reimbursement account, it is wise to be conservative in your estimate of future reimbursable expenses.

If your plan has a Carry Over, you will be allowed to carry over a maximum of $500. Any amount in excess of $500 will be forfeited at the end of the period for filing claims for the prior plan year and cannot be cashed out or converted to any other taxable or nontaxable benefit.

You will receive statements periodically to remind you how much is left in your account. This money must be used for expenses incurred before the end of the Plan Year or subsequent Grace Period, if applicable or be forfeited if the plan does not have carry over or if the plan has carry over it is in excess of $500. **Error! No document variable supplied.**You may submit claims up to 90 days after the Plan Year end including The Grace Period, if applicable, for the prior year's expenses. Employees who terminate employment during the Plan Year will be given three months from their date of termination in which to submit request for reimbursement for expenses incurred before termination.

Disbursements Procedure

To receive reimbursement, you must complete a claim form with a statement that expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source and submit it along with third party documentation showing the person receiving the services, the provider, the amount of the services and requested reimbursement, the nature or type of services and the date of the services (i.e. Carriers EOB) to Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan, Plan Administrator, or designee. The Employer has designated Wexford-Missaukee Intermediate School District to be the claims administrator. Once the claims administrator has received the claims, all claims will be processed for reimbursement on a weekly basis. Within 30 days of submission of a claim to your claims administrator, you will be reimbursed the full amount of your eligible expenses up to your elected Medical Reimbursement Account pretax deferral amount less any benefits you have already received for the Plan Year. For Dependent Care claims you will be reimbursed the full amount of your eligible expenses up to the amount of your pre-tax contributions less any benefits you have already received for the Plan Year. The 30-day time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

Claims can be submitted to the Third-Party Administrator: 44North, 1406 N. Mitchell Street, PO Box 700, Cadillac, MI 49601 or fax to: (855) 306-1098

Premium Conversion Account

The purpose of this Plan is to allow employees to select among cash compensation and certain nontaxable benefits, namely coverage under one or more benefit programs maintained by your Employer. This Employer intends that the Plan qualify as a cafeteria plan under Section 125 of the Code and that the benefits provided under the Plan will be eligible for exclusion from Federal Income Tax.

The Premium Conversion Plan is offered as a part of this Flexible Benefit Plan.

The Plan is a “Salary (or wage) Reduction” plan. This means that you pay your share of the cost of your benefits by electing to have your compensation reduced. You will decide on the amount of your salary reduction on an Enrollment and Salary Reduction Form available from your Plan Administrator. The amount of your agreed salary reduction will be placed in a Premium Conversion Account, maintained by your Employer from which payments for premiums for the various insured benefit plans maintained by your Employer in which you participate will be made.

The money you contribute to pay for your benefits is not subject to Federal income, Social Security or Unemployment taxation. Therefore, your benefit costs are quite low, and in some cases, even result in a net increase in spendable income for you, after paying for your benefits.

While the election to receive Health Insurance Plan benefits may be made under this Plan, the benefits will be provided not by this Plan but by the Health Insurance Plan. The types and amounts of benefits available under the Health Insurance Plan, the requirements for participating in the Health Insurance Plan, and the other terms and conditions of coverage and benefits of the Health Insurance Plan are set by the Health Insurance Plan. All claims to receive benefits under the Health Insurance Plan shall be subject to and governed by the terms and conditions of the Health Insurance Plan and their rules, regulations, policies and procedures.

Failure to participate in this Plan assumes you want your salary paid to you in cash.

How the Premium Conversion Account Plan Works
When you become eligible, you will be required to complete a Premium Conversion Plan Enrollment and Salary Reduction Form available from your Plan Administrator. The Form is an agreement between you and your Employer where you and your Employer list the benefits offered for the Plan Year. It will specify the amount you have agreed to contribute towards the cost of these benefits. Your salary reduction amounts will be credited to your Premium Conversion Plan Account, maintained by your Employer, and the funds in this account will be used to pay, on your behalf, the selected plan premiums.

Claims Appeals

Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued there under. Participant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: 44North, 1406 N. Mitchell St. P.O. Box 700 Cadillac, MI 49601CIC Benefit Consulting Group, 1406 N. Mitchell Street, Cadillac, MI 49601, Attn: Claims Appeals. If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 60 days after receipt of the appeal. Participant is entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits. If Participant receives an adverse benefit determination following the final appeal, Participant has the right to bring a civil action under section 502(a) of ERISA.

About Social Security Taxes

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefits you

receive at retirement. This is because Social Security benefits are based on what you earn while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted each year, and is currently $118,500113,700. If your salary is above the TWB your Social Security benefit is not likely to be affected. If your salary were below the TWB, the benefit would be reduced. The tax advantages you gain through this Plan may offset any possible reduction in Social Security benefits.

About Your Retirement Benefits

Reducing your compensation to obtain Benefit Credits under this Plan may in no way affect the amount of any Employer sponsored retirement plan for which you are or may be entitled to except your Social Security benefits mentioned in the above paragraph.

Future of The Flexible Benefit Plan

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you are entitled before the date of the amendment or termination.

Family and Medical Leave

As an employee of Wexford-Missaukee Intermediate School District, you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work-weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for Wexford-Missaukee Intermediate School District at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a new born child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent), a personal health condition, to care for a family member injured during military duty or an exigency leave when a family member is called to active service.

As a participant in the medical part of the Flexible Benefit Plan, you have while on leave under the FMLA the option to continue your health benefits on the same terms and conditions as immediately prior to taking your FMLA leave. You and your eligible dependents shall remain covered under this plan while you are on FMLA leave, as if you were still at work, your coverage will be maintained until you return to work or, if earlier, you notify Wexford-Missaukee Intermediate School District that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before or at the end of the FMLA leave, you and your eligible dependents shall immediately become covered under the plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave. More details on your FMLA leave rights and benefits while on FMLA leave are available for your Plan Administrator.

The following options are available for FMLA payments:

Prepayment: Error! No document variable supplied. Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law.

Pay-As-You-Go: Error! No document variable supplied.

Catch-Up Option: Error! No document variable supplied.

Qualified Medical Child Support Orders

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either:

(1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or

(2) enforces certain laws relating to medical child support. An "alternate recipient" is any child or a Participant who is recognized by a medical child support order as having a right to enrollment under the Participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if he or she received a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

Maternity and Newborn Coverage

Since this Plan may offer maternity and newborn coverage, you are advised that under Federal law, this Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length or stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods.

Administrative Facts

Plan Sponsor and Administrator

The Flexible Benefit Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. For purposes of this Plan, the Employer shall serve as the Plan Administrator.

The Employer has appointed Wexford-Missaukee Intermediate School District whose address is 9907 E. 13th Street, Cadillac MI 49601 and whose telephone number is (231)876-2312 as claims manager/administrator.

Plan Year
The First Plan Year will begin Sunday, September 01, 2013 and ends Sunday, August 31, 2014. The subsequent Plan Year will begin Monday, September 01, 2014. The current Plan Year is a short Plan Year and begins September 01, 2015 and goes through December 31, 2015. The new Plan Year will begin January 01, 2016 and go through December 31, 2016. This plan will renew every January 1st thereafter.

Name of Plan and Employer Plan Identification Numbers
The Employer Identification Number (EIN) assigned to Wexford-Missaukee Intermediate School District by the Internal Revenue Service (IRS) is 38-6028526. The Plan Number (PN) assigned to this Section 125 Cafeteria Plan by the Employer is 504.

The Name of this Plan is Section 125 Cafeteria Plan, established by the Employer, Wexford-Missaukee Intermediate School District, whose address is 9907 E. 13th Street, Cadillac MI 49601. For more information on the Plan Sponsor, see Administrative Facts section. The effective date of this Plan is Sunday, September 01, 2013.

Service of Legal Process
Wexford-Missaukee Intermediate School District the Employer has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Employer by directing the process to the Plan Administrator indicated above.

Classification and Funding
The Plan is classified as a Code Section 125 cafeteria plan by the Internal Revenue Service. It includes a Health Flexible Reimbursement account, (herein called “Medical Reimbursement Account”) classified by the Department of Labor as a “welfare plan”, and includes a Dependent Care Flexible Reimbursement account (herein called “Dependent Care Reimbursement account). The Plan also includes a Premium Conversion Plan. The Plans are funded by employee contributions. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but shall instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Claims
The Plan Administrator will inform you as to the frequency of claim submission(s). The Plan Administrator will pay the claims as expeditiously as possible, at times determined by the Plan Administrator.

Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

Prior Year Claims
The Grace Period for the Medical Reimbursement Plan is 0 days. The Grace Period for the Dependent Care Plan is 0 days. You may submit claims up to **9**0 days after the end of the plan year including the applicable grace period.

Health Insurance Issuer
Currently, there is no health insurer involved in providing benefits to this Plan.

Third Party Administrator
A Third Party Administrator (TPA) is under contract to provide administrative services to this Plan. This provider is described on Schedule A of this document.

Not a Contract of Employment
No provision of the Plan is to be considered a contract of employment between you and the Employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Statement of ERISA Rights

"ERISA Rights" means your rights obtained by Federal Law:

Statement of ERISA Rights:

> **"**As a participant in the Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan you are entitled to certain rights and protection under the Employees Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
>
> - Receive Information About Your Plan and Benefits.
>
> - Examine, without charge, at the plan administrator's office and other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
>
> - Obtain copies of all plan documents and other information upon written request to the plan administrator. The 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.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description (SPD) and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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 you and other 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 or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive explanation of the reason for the denial. You have a 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 under 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 $100 a day until you receive the material 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. If it should happen that the 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 the claim is frivolous. If you have any question about your plan, you should contact the plan administrator. If you have any question about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Administration, (EBSA) U.S. Department of Labor, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 1-866-444-3272.

Patient's Medical Information

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a Health Plan subject to HIPAA, the plan shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards

for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

The Protected Health Information (PHI) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations ("Rules") and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH") include privacy protections impacting handling of the group health plan medical or financial information that could identify an individual.

Protected Health Information (PHI) is information created or received by Plans subject to HIPAA Plans that relates to the past, present or, future individual's physical or mental health condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Protected Health Information (PHI) provisions of HIPAA and its rules include privacy protections impacting group handling health plan medical or financial information that could identify an individual. Individually identifiable information is protected whether it is in electronic, paper or oral format. The HIPAA rules give individuals control over health and financial information related to their health care. PHI may be used only for limited purposes without consent, and in many situations, only upon individual authorization. Regarding their own PHI, they have the right to:

A. Object to using information;

B. Gain access to information;

C. Change information; and

D. Obtain an accounting of any information disclosures.

An underlying principle of the rules is that the "minimum necessary" disclosure should be the standard when using or disclosing information in the normal course of treatment, payment or health plan operations.

You are guaranteed access to your PHI and have the right to: (1) copy and amend health information; (2) receive an accounting of PHI uses; and (3) receive notices of health plans' privacy practices. You have the right to request that PHI use and disclosure be restricted even for treatment and payment purpose.

Certification Requirement
The plan shall disclose PHI, including Electronic PHI, to Authorized Employees of the Employer only upon receipt of a certification by the Employer that the Employer agrees:

A. not to use or further disclose PHI other than as permitted or required by the Privacy Policy or as required by law;

B. to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

C. not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

D. to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures, or any Security Incident, of which the Employer becomes aware;

E. to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

F. to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

G. to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

H. to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

I. if feasible, to return or destroy all PHI and Electronic PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;

J. to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

K. to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

Electronic Data Security Obligations
To the extent the Plan maintains electronic PHI, the Plan will:

A. Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;

B. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;

C. Ensure that the separation is supported by reasonable and appropriate security measures;

D. Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

E. Report to the Plan any security incident involving PHI including any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations of which it becomes aware.

Permitted Uses and Disclosures
The Plan places restrictions on the Employer's use or disclosure of PHI received from the plan or an insurer. Insurers may determine what information will be available to the Plan.

Only Authorized employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Authorized employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan.

The HIPAA Plan may disclose PHI to the Authorized employees of the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Authorized employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the plan and agree to use and disclose PHI only as permitted or required by HIPAA. This includes:

A. Plan's own Payment and Health Care Operations functions including;

   a. Enrollment of eligible individuals;

   b. Eligibility determinations;

   c. Payment for coverage;

   d. Claim payment activities;

e. Coordination of benefits; and

f. Claims appeals.

B. Another HIPAA Health Plan's Payment and Health Care Operations functions;

C. Disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;

D. Disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

E. Disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g)

F. Disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

G. Uses and disclosures to comply with workers' compensation laws;

H. Uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

I. Disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

J. Uses and disclosures for other governmental purposes, such as for national security purposes;

K. Uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

L. Uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes

M. Uses and disclosures required by other applicable laws

N. Uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508

O. Enrollment of eligible individuals;

P. Eligibility determinations; and

Q. Payment for coverage;

The Plan will meet the minimum necessary uses and disclosures provisions of HIPAA for PHI. However, the minimum necessary provisions *do not apply* to the following:

A. Disclosures to or request by a health care provider for treatment purposes;

B. Disclosures to the individual who is the subject of the information;

C. Uses or disclosures made based on an authorization requested by the individual;

D. Uses or disclosures required for compliance with HIPAA's transaction standards (see 813);

E. Disclosures to HHS when the rule requires the disclosure of information for enforcement purpose; or

F. Uses or disclosures that are required by other laws.

Any uses or disclosures for which the covered entity has a valid authorization are exempt.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Marketing
The group health plan(s) and other covered entities, as defined by HIPAA, will not use or disclose PHI for marketing purposes without your authorization, except for face-to-face communications with the individual or promotional gifts of nominal value.

Communications that are part of treatment or are about a plan's benefits, services or operations are excluded from the definition of marketing, even if they promote the use or sale of a service or product. Specifically excluded from the definition of marketing communications about:

A. Participating providers and health plans in a network, the services offered by a provider or the benefits covered by a health plan;

B. Treatment of the individual; and

C. Case management or care coordination for the individual, or directions or recommendations for alternative treatments, therapies, health care providers or settings of care to that individual.

This health plan is not engaging in marketing when it advises enrollees about other available health coverage that could enhance or substitute for existing health coverage. For example, if a child is about to age out of coverage under a family policy, the plan may send the family information about continuation coverage for the child. This exception does not extend to excepted benefits under HIPAA, such as accident-only policies or auto medical liability, nor to other lines of insurance. For example, a multi-line insurer may not use PHI to promote its life insurance policies.

It is not marketing for a health plan to communicate about health-related products and services available only to plan enrollees or members that add value to but are not part of a plan of benefits. To qualify for this exclusion, the communication must meet two conditions:

A. It must be health-related. For example, offers of discounts for eyeglasses may be considered part of plan benefits. This exclusion appears to include wellness programs that offer incentives to adopt healthy lifestyle behaviors.

B. It must offer an added value of plan membership and not merely be a pass-through of a discount or item available to the public at large. Thus, a plan could offer its members a special discount for a health/fitness club, but not pass along to its members' discounts that the members could obtain directly from the club.

For marketing activities permitted by an authorization, if there is remuneration, the marketing material must state that the entity making the communication is being paid by another entity.

Prohibited Uses and Disclosures
Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health information is prohibited in the following situations:

A. *Genetic Information*. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

B. *Employment-Related Actions*. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

C. *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted above, shall not be a permitted use or disclosure.

Plan administration functions do not include functions performed by the Employer for employment-related functions.

The Authorized employees will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of the Plan.

Underwriting
An insurer that receives protected group health plan information for underwriting, premium rating and other similar purpose – and that coverage is not placed with the insurer- cannot use or disclose the information for any purpose other than as required by law.

Verification
In any disclosure, other than those allowing the individual to agree or object, verifying the identity of anyone requesting PHI who is not known to the health plan or other covered entity must first occur.

If disclosure is conditional on documentation or statements from the person-seeking PHI, that documentation or statement must be obtained before the PHI can be disclosed.

Breach Notification
Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Legal Control

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. This Plan is part of another Plan, The Flexible Benefit Plan, so your specific rights to benefits under the Plan are governed solely, and in every respect, by Wexford-Missaukee Intermediate School District Flexible Benefits Plan Document, and this Flexible Benefit Plan Summary Plan Description, copies of which is available from the Plan Administrator or his designee, upon your request. (See statement of ERISA rights.) If there is a discrepancy between the description of the Plan as contained in this material, and the official Plan Document, the language of the Flexible Benefit Plan Document will apply.

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Schedule A

Schedule of Benefits

Medical Reimbursement Account
Eligible Medical Expenses:

Medical Expenses, Dental Expenses, Vision Expenses

Restriction on Reimbursement of Medicines and Drugs. Notwithstanding any other provision of the Plan to the contrary, effective January 1, 2011, Medical Care Expenses eligible for reimbursement under the Medical FSA component shall include expenses for medicines or drugs incurred after December 31, 2010 only if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied.

Employee Annual Contribution Limitations*
Pay Period for Annual Payroll Contributions: bi-weekly

	Minimum	Maximum
Section 125 Cafeteria Plan	$0.00**	$ 2500.00**

*Employee designated salary reduction and allocation subject to the limitations set forth.

**Employer contributions may be used as indicated in the Funding paragraph of Section IV of the Plan Document. In no event, may the Employer Contribution and the Employee Contribution together exceed the Employee Contribution Limitation above.

**The Employee contributions necessary to obtain the coverage's set forth in this Schedule A above will be communicated by the Plan Administrator to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period, as included in the Summary Plan Description of the Benefit. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Schedule A continued

**Minimum to be determined by Plan Administrator and maximums by allowed maximums which may be, at the Plan Administrator's discretion, indexed for cost-of-living adjustments in accordance with Code Section 125(i)(2). Plan Administrator will communicate the allowed maximum to eligible employees upon commencement of participation and to Participants at the time of the Enrollment Period. Minimum & Maximum Amounts calculated based on Proper Pay. As of the first day of the plan year, the election is irrevocable during the plan year unless there is a change in family status as defined in this document.

Claims can be submitted to the Third-Party Administrator:

44North – Cadillac Office
1406 N. Mitchell Street
PO Box 700
Cadillac, MI 49601

Or Faxed to: (855) 306-1098

List, if desirable, names and addresses and phone numbers of provider of insured benefits.

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Schedule B

Schedule of Benefits

Dependent Care Reimbursement Account
Employee Annual Contribution Limitations*
Pay Period for Annual Payroll Contributions: bi-weekly

	Minimum	Maximum
Section 125 Cafeteria Plan	$0.00**	$ 2500.00**

*Minimum Contribution as determined by the Employer.

**Maximum Contribution according to Internal Revenue Code Section 129 is $5,000 for a married couple filing a joint federal income tax report, or $ 2,500 for a married employee filing separately.

**Employer contributions may be used as indicated in the Funding paragraph of Section III of the Plan Document. In no event, may the Employer Contribution and the Employee Contribution together exceed the Employee Contribution Limitation above.

**The Employee contributions necessary to obtain the coverage set forth in this Schedule B will be communicated by the Plan Administrator to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period, as included in the Summary Plan Description of the Benefit. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

**Minimum to be determined by Plan Administrator and maximums by allowed maximums which may be, at the Plan Administrator's discretion, indexed for cost-of-living adjustments in accordance with Code Section 125(i)(2). Plan Administrator will communicate the allowed maximum to eligible employees upon commencement of participation and to Participants at the time of the Enrollment Period. Minimum & Maximum Amounts calculated based on Proper Pay. As of the first day of the plan year, the election is irrevocable during the plan year unless there is a change in family status as defined in this document.

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Schedule B continued

Claims can be submitted to the Third-Party Administrator:

44North – Cadillac Office
1406 N. Mitchell Street
PO Box 700
Cadillac, MI 49601

Or Faxed to: (855) 306-1098

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Schedule C

Schedule of Benefits

Premium Conversion Plan
Pay Period for Annual Payroll Contributions: bi-weekly

Benefit Programs	Coverage Tiers	Employee Contributions
Health Insurance Plan		
	Employee Only	$**
	Employee & Spouse	$**
	Employee & Child	$**
	Employee & Family	$**
Dental Plan		
	Employee Only	$**
	Employee & Spouse	$**
	Employee & Child	$**
	Employee & Family	$**
Vision Plan		
	Employee Only	$**
	Employee & Spouse	$**
	Employee & Child	$**
	Employee & Family	$**

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Schedule C continued

Voluntary Plans

Employee Only	$**
Employee & Spouse	$**
Employee & Child	$**
Employee & Family	$**

**The Employee contributions necessary to obtain the coverage options set forth in this Schedule C will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period.

Required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option provided above.

The Employee share of the cost of these benefits may be adjusted from time to time to reflect the change in rates charged by the carriers or to comply with Michigan Public Act 152 of 2011 requirements (If Applicable).

Participation in this Plan is conditioned upon the participant completing the **Enrollment Form** provided to each Participant at the time of your enrollment. As of the first day of the plan year, the election is irrevocable during the plan year unless there is a change in family status as defined in this document.

List any Affiliated Employer who has adopted this Plan with name, address and phone numbers.

There are no other Employers affiliated with this plan.

Wexford-Missaukee Intermediate School District Section 125 Cafeteria Plan
Summary Plan Description
Amended July 01, 2017

Appendix A

Continuation of Coverage

In General.
The following provisions shall apply to Benefits provided to Eligible Employees and their dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA) unless the employer is exempt.

Continuation of Coverage.
To the extent required by COBRA, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

Participants in this Plan may receive all the benefits and requirements of COBRA previously stated except for Cessation of Participation in this Flexible Benefit Plan with Regards to benefits remaining at time of Qualifying Event. The Participant's participation will cease at the end of the Plan Year during which the Qualifying Event occurs.

Notwithstanding the above provisions, a Participant will cease to be a Participant on the last day of the plan year in which a qualifying event occurs.

However, if the Participant has any unused benefits remaining at the termination of participation, the participant will be allowed to claim those benefits for dates of service incurred on or prior to the termination date. The unused portion will be forfeited three months following the Employee's date of termination or three months after the end of the Plan Year, whichever is earlier.

Type of Coverage.
Continuation coverage under this provision is coverage, which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with

respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

COBRA coverage under the Medical Reimbursement Account will be offered only to qualified beneficiaries losing coverage who have under spent accounts. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Medical Reimbursement Account coverage that will be charged for the remainder of the Plan Year.

COBRA coverage will consist of the Medical Reimbursement Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

Coverage Period.
The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;

B. in the case of a qualified beneficiary disabled during the first 60 days following the covered Employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event; Note: The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The qualified beneficiary receiving the disability extension is required to notify the Plan Administrator if the SSA makes such a determination, and you must provide this notice within the 30-day period after the SSA makes such a determination. Such a notice is to be in writing and delivered in person or mailed to the Plan Administrator.

C. in the case of a terminated Employee (except for gross misconduct) or covered Employee whose hours have been reduced, and the employee became entitled to Medicare less than 18 months before the qualifying event, for the covered dependents, the date which is 36 months after the date of Medicare entitlement.

D. in the case of a second qualifying event, which includes the death of a covered employee, the divorce of a covered employee and spouse, or a loss of dependent status under the plan, which occurs during the 18-months after the

date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, you may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage). The affected individual is entitled to this continuation coverage period only if it would have caused a loss of coverage under the plan, in the absence of the first qualifying event. The affected individual is required to notify the Plan Administrator in the same manner as Section B Above.

E. in the case of any qualifying event except as described in A., B., and C. above, the date which is 36 months after the date of the qualifying event;

F. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any Employee;

G. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;

H. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event, will coverage continue longer than the coverage period as set forth in this Section.

I. The right of continuation coverage under the Plan may be terminated prior to the end of the continuing coverage period if the individual engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary.

J. The Plan Administrator is required to give notice of Unavailability of Continuation Coverage should the right of continuation coverage be denied or terminated. This Notice of Unavailability of Continuation Coverage will state the specific reason for denial of the claim for continuation coverage. The individual will be notified of the date the coverage will terminate, and the reason for termination and the rights the qualified beneficiary may have under the plan or applicable law, or to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Contribution

A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer or a participating Employer in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments. The

election notice will contain complete information as to the amount of the premium required.

B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

D. Certain individuals may be eligible for a Federal Income tax credit as a result of the Trade Adjustment Assistance Reform Act of 2002 (HCTC). This tax credit helps pay for the premium of continuation coverage. An individual who loses a job due to the effect of international trade may be entitled to this tax credit (payable in some cases directly to the employer to offset the cost of the premium) and qualify for trade adjustment assistance. Those receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) may become entitled to the tax credit as well. If you become entitled to this tax credit, contact HCTC Customer Contact Center at 1-866-628-4282.

Notification by Qualified Beneficiary.
Each covered Employee or qualified beneficiary must notify the Employer or a participating Employer in writing of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within **60** days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph, which occur after the date of the enactment of the Tax Reform Act of 1986.

Keep Your Plan Informed of Address Changes. In order to protect you and your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of yourself and/or family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notification Procedure.
Any notice that you provide must be in writing addressed to the employer. Oral notice, including notice by telephone, is not acceptable. Electronic notices (email or fax) are not acceptable. Your notice must be complete and must be postmarked no later than the last day of the required notice period. Your notice must state the name and address of the Employer, the name of the group health plan, the name and address of the employee covered under the plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

Your notice of a second qualifying event must also name the event and the date it happened.

Your notice of a child's loss of dependent status must include documentation of the date of the qualifying event (i.e., a birth certificate, marriage certificate, or transcript showing the last date of the enrollment in an education institution). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA.

If the qualifying event or the second qualifying is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability or cessation of disability must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled or ceased to be disabled and the date the Social Security Administration made its determination. Your notice of disability or cessation of disability must include a copy of the Social Security Administration's determination.

Notification to Qualified Beneficiary.

A. The Employer or a participating Employer shall provide written notice to each covered Employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

B. The Employer or a Participating Employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, Wexford-Missaukee Intermediate School District, shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies Wexford-Missaukee Intermediate School District of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

C. Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

Appendix A Definitions.

A. **"Dependents"** means an individual who meets the definition of dependent under the Participating Employer provided health plan covering the Eligible Employee. For the purposes of the Medical Reimbursement Plan, if any, dependents will also include individuals who are dependents within the meaning of section 152(a) of the Code, and as defined in section 1 of the Plan Document. No person shall be considered a dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by the Employer or a participating Employer, dependent children may be covered by either spouse, but not by both.

B. "**Election Period"** means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

C. **"Full-Time Student"** means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

D. **"Medicare"** means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

E. **"Qualified Beneficiary"** means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the dependent (as defined in Section 1 hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term qualified beneficiary includes the covered Employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary.

Exception - the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code section 911(d)(2) and section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

F. **"Qualifying Event"** means with respect to a covered Employee, any of the following events, which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

i. the death of the covered Employee;
ii. the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered employee's employment;
iii. divorce or legal separation of the covered Employee from such covered Employee's spouse, as herein defined;
iv. the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
v. a dependent child who ceases to be a dependent child under the terms of this Plan;

vi. the Company's filing for Chapter 11 reorganization, as it would affect retiree coverage.

G. **"University/College"** means an accredited institution listed in the current publication of accredited institutions of higher education.