THIS DOCUMENT IS AN AMENDED AND RESTATED

PLAN DOCUMENT

FOR THE

BERRIEN REGIONAL EDUCATION SERVICE AGENCY

CAFETERIA PLAN

Effective Date of Amended and Restated Cafeteria Plan:

July 1, 2017

Group Number: G-731

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CAFETERIA PLAN

ARTICLE I: ESTABLISHMENT OF PLAN

1.1 Establishment of Plan

The **BERRIEN REGIONAL EDUCATION SERVICE AGENCY CAFETERIA PLAN** was established by **Berrien Regional Education Service Agency**, effective as of December 1, 2005. The Plan is being amended and restated effective as of July 1, 2017. Each provision of the Plan applies from its effective date until the effective date of an amendment. The purpose of the Plan is to permit an Employee to choose between Compensation and Qualified Benefits offered under the Plan.

1.2 Compliance with Law; Interpretation

The Plan is intended to be a cafeteria plan under Code Section 125 and all regulations issued thereunder. The Benefits under the Plan are provided by means of Component Programs that also are intended to meet the applicable requirements of the Code. References to any section of the Code shall be deemed to include similar sections of the Code as they may be renumbered or amended from time to time. The Plan shall be interpreted and administered in compliance with those requirements. To the extent not superseded or pre-empted by federal law, the Plan shall also be interpreted and administered in compliance with the laws of the state of Michigan.

ARTICLE II: DEFINITIONS

The following terms used in the Plan and other documents relating to the Plan shall have the meanings described in this article unless the context clearly indicates another meaning. All references in the Plan to specific articles or sections shall refer to articles or sections of the Plan unless otherwise stated.

2.1 ACA

The term "ACA" means the Patient Protection and Affordable Care Act, as amended, including any applicable regulations.

2.2 Account; Accounts

The term "Account" or "Accounts" means the bookkeeping account(s) established and maintained to record the amount of reimbursement benefits available to a Participant under the Medical Reimbursement Program and the Dependent Care Reimbursement Program.

2.3 Administrative Functions

The term "Administrative Functions" mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan.

Administrative Functions include quality assurance, employee assistance, claims processing, auditing, and monitoring. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative Functions specifically do not include any employment-related functions.

2.4 Benefit Program; Benefit Programs

The term "Benefit Program" or "Benefit Programs" means the welfare benefit plan(s) offered by the Employer, as periodically amended, including the SHOP Exchange.

2.5 Benefit Provider

The term "Benefit Provider" means the provider of a Benefit Program or welfare benefit plan.

2.6 Benefits

The term "Benefits" means those benefits described in and provided under a Component Program.

2.7 Business Associate

The term "Business Associate" means a person or entity that does the following:

(a) performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

(b) provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

2.8 Calendar Year

The term "Calendar Year" means the 12-consecutive-month period beginning January 1 and ending December 31.

2.9 Claim Administrator

The term "Claim Administrator" means the entity designated to be responsible for the administration of some or all of the benefits under the Plan, as provided in article X.

2.10 COBRA

The term "COBRA" means the health care continuation provisions of the Public Health Services Act, as amended.

2.11 Code

The term "Code" means the Internal Revenue Code of 1986, as amended, including any applicable regulations.

2.12 Compensation

The term "Compensation" means salary, hourly wages, overtime pay, incentive pay, bonuses, commissions, severance pay, and other amounts paid to an Employee for personal services performed for the Employer.

2.13 Component Program; Component Programs

The term "Component Program" or "Component Programs" means the program(s) offered by the Employer under article IV.

2.14 Dependent

The term "Dependent" means the following:

(a) For purposes of paying the cost of coverage under an Employer-provided Benefit Program, the term "Dependent" is defined in the same manner as defined in the Employer-provided Benefit Program. If the Dependent is an individual defined under Section 152 of the Code, but determined without regard to Code Sections 152(b)(1), (b)(2), and (d)(1)(B), or is a Participant's child within the meaning of Code Section 152(f)(1) until at least the child's 26th birthday or, if provided in the Employer-provided Benefit Program, until the end of the month or end of the Calendar Year the child attains age 26 (whichever time period is consistent with the Employer-provided Benefit Program), then the Participant may pay the cost of the Dependent's coverage on a pre-tax basis. If the Dependent does not come within this definition, the Participant may still pay for the cost of the Dependent's coverage on a pre-tax basis if the fair-market value of the coverage is included in the participating Employee's gross income.

(b) For purposes of obtaining reimbursement under the Medical Reimbursement Account, the term "Dependent" means an individual defined in Code Section 152, but determined without regard to Code Sections 152(b)(1), (b)(2), and (d)(1)(B), or a Participant's child within the meaning of Code Section 152(f)(1) through the end of the Calendar Year the child attains age 26 or, if established by Employer in writing, an earlier date that shall be no earlier than the child's 26th birthday.

(c) For purposes of the Dependent Care Reimbursement Account, the term "Dependent" is defined in Section 8.3(a).

2.15 Dependent Care Reimbursement Account

The term "Dependent Care Reimbursement Account" means the Account established and maintained by the Employer to record the Participant's Benefits allocation to the Dependent Care

Reimbursement Program described in article VIII. The Dependent Care Reimbursement Program shall be considered a separate plan to the extent required by the Code.

2.16 Election

The term "Election" means the Participant's choice between taxable Compensation and Qualified Benefits as evidenced by an Election Form that the Participant has properly completed, executed, and returned to the Plan Administrator, as provided in article III. The election process may be carried out in writing or electronically (such as through an online or telephonic system). All references to an Election in the Plan shall be interpreted accordingly. Employees shall be notified of the election procedures.

2.17 Election Form

The term "Election Form" means the agreement entered into between the Employer and a Participant, as provided in article III. The election process may be carried out in writing or electronically (such as through an online or telephonic system). All references to an Election Form in the Plan shall be interpreted accordingly. Employees shall be notified of the election procedures.

2.18 Employee

The term "Employee" means an individual who, for tax purposes, is considered by the Employer to be in its employ. The term Employee does not include an independent contractor, a leased employee, a more-than-two-percent shareholder in an S corporation, or a self-employed individual, including a partner or sole proprietor of the Employer.

2.19 Employer

The term "Employer" means **Berrien Regional Education Service Agency**.

2.20 FMLA

The term "FMLA" means the Family and Medical Leave Act of 1993, as amended, including any applicable regulations.

2.21 Highly Compensated Employee

The term "Highly Compensated Employee" means, for any Plan Year, a person who is a highly compensated employee for that Plan Year as defined in Code Section 414(q).

2.22 Highly Compensated Participant

The term "Highly Compensated Participant" means a Participant who is one of the following: (a) an officer of the Employer; (b) a Highly Compensated Employee; or (c) a spouse or dependent of an individual described in (a) or (b) above, as further defined in Code Section 125(e)(1).

2.23 HIPAA

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, including any applicable regulations.

2.24 HMO

The term "HMO" means health maintenance organization.

2.25 Maximum Contribution

The term "Maximum Contribution" means the maximum amount a Participant may contribute to a Component Program for a Plan Year. The Maximum Contribution for each Component Program is set forth in the article of this Plan describing that Component Program.

2.26 Medical Reimbursement Account

The term "Medical Reimbursement Account" means the Account established and maintained by the Employer to record the Participant's Benefits allocation to the Medical Reimbursement Program described in article VII. The Medical Reimbursement Program shall be considered a separate plan to the extent required by the Code.

2.27 Open Enrollment Period

The term "Open Enrollment Period" means, with respect to each Plan Year, the time period for a Participant to make Elections for that Plan Year. The Employer shall establish the Open Enrollment Period, which shall precede the first day of the Plan Year.

2.28 Participant

The term "Participant" means a current or former Employee who has met the eligibility requirements of any Component Program and who is enrolled in the Plan or who is specifically authorized to participate in the Plan.

2.29 Plan

The term "Plan" means the **Berrien Regional Education Service Agency Cafeteria Plan** as it may be amended from time to time, and any Component Program that is a part of the Plan.

2.30 Plan Administrator

The term "Plan Administrator" means the named fiduciary responsible for the operation and administration of the Plan. The Plan Sponsor shall be the Plan Administrator.

2.31 Plan Sponsor

The term "Plan Sponsor" means **Berrien Regional Education Service Agency**.

2.32 Plan Year

The term "Plan Year" means each 12-consecutive-month period beginning **July 1** and ending **June 30**.

2.33 Protected Health Information

The term "Protected Health Information" or "PHI" means information that is created or received by the Plan or a Business Associate and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant. Also, the information identifies the Participant or there is a reasonable basis to believe the information can be used to identify the Participant (whether living or deceased). The following components of a Participant's information will enable identification:

- names
- street address, city, county, precinct, ZIP code
- dates directly related to a Participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death
- telephone numbers, fax numbers, and electronic mail addresses
- social security numbers
- medical record numbers
- health plan beneficiary numbers
- account numbers
- certificate/license numbers
- vehicle identifiers and serial numbers, including license plate numbers
- device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- biometric identifiers, including finger and voice prints
- full face photographic images and any comparable images
- any other unique identifying number, characteristic, or code

2.34 Qualified Benefits

The term "Qualified Benefits" means qualified benefits as defined in Code Section 125(f).

2.35 SHOP Exchange

The term "SHOP Exchange" means coverage from a qualified health plan pursuant to Code Section 125(f)(3) that is offered through an exchange established by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education and Reconciliation Act of 2010.

2.36 Spouse

The term "Spouse" means the following:

(a) For purposes of paying the cost of coverage under an Employer-provided Benefit Program, the term "Spouse" is defined in the same manner as defined in the Employer-provided Benefit Program. If the Spouse is the Employee's legally married Spouse as determined by the laws of the state or jurisdiction where the marriage occurs, or if the Spouse is an individual defined under Section 152 of the Code, but determined without regard to Sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code, then the Participant may pay the cost of the Spouse's coverage on a pre-tax basis. If the Spouse does not come within this definition, the Participant may still pay for the cost of the Spouse's coverage on a pre-tax basis if the fair-market value of the coverage is included in the participating Employee's gross income.

(b) For purposes of obtaining reimbursement under the Medical Reimbursement Account, the term "Spouse" means the Employee's legally married Spouse as determined by the laws of the state or jurisdiction where the marriage occurs. This definition applies regardless of the laws of the state or jurisdiction where the couple resides.

(c) For purposes of determining the maximum amount that may be credited to a Participant's Dependent Care Reimbursement Account during a Calendar Year as set forth in Section 8.6, the term "Spouse" means the Employee's legally married Spouse as determined by the laws of the state or jurisdiction where the marriage occurs.

2.37 Summary Health Information

The term "Summary Health Information" means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan. The information described in 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

ARTICLE III: ELIGIBILITY AND PARTICIPATION

3.1 Eligibility and Participation

The eligibility and participation rules for each Component Program under the Plan shall be set forth in the article of this Plan describing that Component Program. All Participants in the Plan must be current or former Employees.

3.2 Initial Election by Newly Eligible Employees

The Employer shall provide a newly eligible Employee with an Election Form on or before the date the Employee becomes eligible to participate in this Plan. The Employee must return the completed Election Form to the Plan Administrator on or before the date specified by the Plan Administrator, which will precede the Employee's entry into the Plan. However, if an Employee becomes eligible upon the Employee's date of hire and makes an Election within the next 30 days, the Election shall be effective retroactively as of the Employee's date of hire.

The Employer shall deem that an Employee who fails to return a completed Election Form by the specified date has elected to receive his full Compensation for the Plan Year in cash and has waived all benefits under the Plan. However, the Employer shall add any additional Compensation for waiving coverage under an Employer-provided Benefit Program to the Participant's Compensation. Except as provided in section 3.4, the Participant may make no Election for the Plan Year after the specified date.

3.3 Annual Election Procedure

With respect to the Pre-Tax Premium Payment Program, the Employer shall automatically continue a Participant's Election from a previous Plan Year for each subsequent Plan Year unless one of the following two exceptions applies:

(a) The Participant completes a new Election Form and returns it to the Plan Administrator during the Open Enrollment Period before the first day of the subsequent Plan Year.

(b) The Employer requires the Participant to complete a new Election Form for a subsequent Plan Year.

If neither one of these exceptions applies, the Participant's Election from the previous Plan Year shall automatically continue for the subsequent Plan Year, and the Employer shall deem that the Participant has agreed to make Compensation reductions equal to the full purchase price for the Qualified Benefits previously elected, including any increases in the purchase price for the subsequent Plan Year. Except as provided in section 3.4, the Participant may make no Election for the Plan Year after the specified date.

With respect to the Medical Reimbursement Program and the Dependent Care Reimbursement Program, the Employer shall provide an Election Form to each Participant during the Open Enrollment Period before the first day of each Plan Year. An Election shall be valid for the Plan Year for which the Participant makes the Election. The Participant must return the completed Election Form to the Plan Administrator on or before the date specified by the Plan Administrator, which will precede the first day of the Plan Year.

The Employer shall deem that a Participant who fails to return a completed Election Form by the specified date has elected to waive participation in the Medical Reimbursement Program and the Dependent Care Reimbursement Program for the Plan Year. The Employer shall therefore allocate no amounts to the Participant's Medical Reimbursement Account or Dependent Care Reimbursement Account for the Plan Year. Except as provided in section 3.4, the Participant may make no Election for the Plan Year after the specified date.

3.4 Irrevocability of Election

A Participant may not change or revoke an Election made for a Plan Year except as follows:

(a) A Participant may automatically change Compensation reductions, on a prospective and reasonable and consistent basis, to reflect any increase or decrease in the cost of coverage under a Benefit Program in which the Participant or Participant's Spouse or Dependent is enrolled. However, if the cost increase or

decrease is significant, the Participant may make one of the following Election changes:

(i) If the cost decrease for an option is significant, the Participant may elect a corresponding decrease in the amount of Compensation reductions. Subject to the special enrollment rights rules of HIPAA, where the cost decrease for an option is significant, the Participant may also elect to commence participation in the option even though the Participant had not previously elected that option for the Plan Year.

(ii) If the cost increase for an option is significant, the Participant has the following choices:

(A) To elect a corresponding increase in the amount of the Participant's Compensation reductions.

(B) To revoke the Participant's current Election and elect other similar coverage on a prospective basis.

(C) To drop coverage if another option providing similar coverage is not available.

A cost increase or decrease may include a situation where the change is caused by an action taken by the Participant (such as switching from full-time to part-time status, or vice-versa, or changing job classifications) or an action taken by the Employer (such as changing the amount of Compensation reductions for a class of Employees). This subsection does not apply to a Participant's Medical Reimbursement Account.

(b) A Participant may change Compensation reductions with respect to the Participant's Dependent Care Reimbursement Account, on a prospective and reasonable and consistent basis, to reflect any increase or decrease in the cost of Dependent Care Services. However, this Election change rule shall not apply if the dependent care provider is a relative as described in Code Section 152(a)(1) through (8), incorporating the rules of Code Section 152(b)(1) and (2).

(c) A Participant may change an Election if coverage under a Benefit Program in which the Participant or the Participant's Spouse or Dependent is enrolled is significantly curtailed. The Participant may elect to receive prospective coverage under another Benefit Program offered by the Employer that provides similar coverage. In addition, if the significant curtailment is a loss of coverage, the Participant also may elect to drop coverage if no similar alternative coverage is available. The Plan Administrator shall determine whether the Participant has experienced a loss of coverage in accordance with regulations and other guidance issued by the U.S. Department of Treasury. This subsection does not apply to a Participant's Medical Reimbursement Account.

(d) A Participant may change an Election on account of and consistent with a "change in status," as provided in section 3.5.

(e) A Participant may change an Election to satisfy any nondiscrimination rule in the Code.

(f) A Participant may change an Election if the Participant goes on an FMLA leave and changes the Election in accordance with section 3.9.

(g) A Participant may change an Election if the Employer offers a new or significantly improved benefit or coverage option. The Participant may prospectively elect the new or significantly improved option. This subsection does not apply to a Participant's Medical Reimbursement Account.

(h) A Participant may prospectively change an Election if it is on account of and corresponds with a change under another group health plan either of the Employer or another employer (Other Plan) and either of the following conditions are met:

(i) The Other Plan permits an election change that would be permitted under this section.

(ii) The Plan Year under this Plan is different from the plan year (for election purposes) under the Other Plan.

This subsection does not apply to a Participant's Medical Reimbursement Account.

(i) A Participant may change an Election regarding health coverage under a Benefit Program in order to exercise special enrollment rights under HIPAA, even if the change in Election would not be permitted under section 3.5. If the special enrollment rights situation is the addition of a new Spouse or Dependent, a Participant's election to enroll previously existing Dependent children shall also be allowed. Such an Election change may be funded through Compensation reductions only on a prospective basis, except in the case of a permitted retroactive Election made within 30 days of a birth, adoption, or placement for adoption. Further, a Participant has special enrollment rights if the Participant's Medicaid or a state's Children's Health Insurance Program (CHIP) coverage is terminated as a result of a loss of eligibility, or if the Participant becomes eligible for a premium-assistance subsidy under Medicaid or a CHIP to obtain coverage under the Employer's group health coverage. In this latter case, the Participant must make the new election within 60 days after the event occurs.

(j) A Participant may change an Election with respect to accident or health coverage because of a court order resulting from divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant. Specifically, the Participant may do either of the following:

(i) Elect coverage for the child if the court order requires accident or health coverage under the Employer's Benefit Program in which the Participant is enrolled.

(ii) Cancel coverage for the child if the court order requires the Spouse, former Spouse, or other individual to provide accident or health coverage for the child and the other coverage is actually provided.

(k) If a Participant or a Participant's Spouse or Dependent becomes entitled to coverage under Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits), the Participant may prospectively elect to cancel or reduce accident or health coverage under the Employer's Benefit Program for the individual. In addition, if a Participant or a Participant's Spouse or Dependent who has been entitled to coverage under Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits) loses eligibility for such coverage, the Participant may elect to prospectively commence or increase accident or health coverage under the Employer's Benefit Program for the individual.

(l) If a Participant or a Participant's Spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, the Participant may prospectively add Employer-provided accident or health coverage for the individual. This subsection does not apply to a Participant's Medical Reimbursement Account.

(m) Notwithstanding Section 3.5(a)(ii), if a Participant has a change in employment status so that the Participant's hours of service will be reasonably expected to be reduced to an average of fewer than 30 hours of service per week, the Participant may elect to cancel health coverage under Employer's Benefit Program even if the reduction in hours does not result in the Participant ceasing to be eligible for the health coverage. This revocation election is permissible provided that it corresponds to the intended enrollment of the Participant and the Participant's Spouse and Dependent(s), if applicable, in another plan that provides minimum essential coverage (as that term is defined in the ACA) and that is effective no later than the first day of the second month following the month that includes the date health coverage under Employer's Benefit Program is revoked. This subsection does not apply to Participant's Medical Reimbursement Account.

(n) If a Participant is eligible to enroll in a qualified health plan (as that term is defined in the ACA) through an exchange during a special enrollment period or annual open enrollment period, the Participant may elect to cancel health coverage under Employer's Benefit Program. This revocation election is permissible provided that it corresponds to the intended enrollment of the Participant and the Participant's Spouse and Dependent(s), if applicable, in a qualified health plan that is effective no later than the day immediately following the date health coverage under Employer's Benefit Program is revoked. This subsection does not apply to a Participant's Medical Reimbursement Account.

In no event may a Participant change an Election for a Plan Year after the Plan Year ends.

3.5 Change in Status

A Participant may change an Election during a Plan Year on account of a change in status that satisfies the requirements of this section.

(a) Events. The following events are changes in status for purposes of this section:

(i) Dependent Eligibility. An event that causes a Participant's Dependent to satisfy or cease to satisfy the requirements for coverage because of the attainment of a specified age, student status, or any similar circumstance.

(ii) Employment Status. An event affecting the employment status of the Participant or the Participant's Spouse or Dependent, including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual's eligibility for benefits.

(iii) Legal Marital Status. An event that changes the Participant's legal marital status, including marriage, death of the Participant's Spouse, divorce, legal separation, and annulment.

(iv) Number of Dependents. An event that changes the number of a Participant's Dependents, including birth, adoption, placement for adoption, and death of a Dependent.

(v) Residence. A change in the place of residence of the Participant or the Participant's Spouse or Dependent that affects the Participant's previous Election.

(b) Consistency Requirement. If a Participant has a change in status under subsection (a), a Participant may change an Election in accordance with subsection (c) if the applicable consistency requirement is satisfied as follows:

(i) With respect to Employer-provided accident or health coverage, the Election change must be on account of and correspond with a change in status that affects eligibility for coverage. If a Participant seeks to decrease or cancel coverage because he becomes eligible for coverage under the plan of the employer of his Spouse or Dependent owing to a legal marital or employment change in status, the change shall be permitted only if the Participant is actually obtaining or will be obtaining coverage under the Other Plan, as defined in Section 3.4(h).

(ii) With respect to the Medical Reimbursement Account, a Participant's election to decrease the annual contribution amount below the amount the Plan has already reimbursed the Participant for the Plan Year shall automatically be considered to not satisfy the consistency requirement described in this subsection (b).

(iii) With respect to the Dependent Care Reimbursement Account, the Election change must be on account of, and correspond with, a change in status that affects Dependent Care expenses (e.g., the Dependent ceases to be a Qualifying Individual).

(c) Procedural Requirements. A Participant who has a change in status that satisfies the requirements of subsections (a) and (b) must submit a new Election Form to the Plan Administrator no later than 30 days after the change in status occurs. Any new Election under this section shall be effective at the time prescribed by the Plan Administrator. Further, the Plan Administrator will approve any new Election involving an HMO or independent, third-party provider only to the extent permitted by the HMO or independent, third-party provider.

3.6 Termination of Participation

If an individual stops working in an eligible job classification or terminates employment, the Plan Administrator shall consider that the individual has terminated participation in the Plan as of the last day the individual was an eligible Employee.

The following rules shall apply to an individual who terminates participation under the Plan:

(a) Except as provided in section 6.1(b), the individual shall be ineligible to have additional Compensation reductions applied to pay Premiums to purchase coverage under the Employer's Benefit Programs or to receive additional Compensation for waiving coverage under the Employer's Benefit Program. The individual's continued participation and coverage under the Employer's Benefit Programs shall be determined under the terms and conditions of each of those separate Benefit Programs.

(b) The individual shall be ineligible to have additional amounts applied to his Medical Reimbursement Account and Dependent Care Reimbursement Account. Any amounts remaining in the individual's Medical Reimbursement Account may continue to be applied toward the reimbursement of claims for eligible expenses incurred before the date the individual's participation terminated. However, the individual shall not be eligible to be reimbursed for claims for eligible expenses incurred after the date the individual's participation terminated, except to the extent the individual continues to participate in the Medical Reimbursement Account as described in section 3.7. Any amount remaining in the individual's Dependent Care Reimbursement Account may continue to be applied toward the reimbursement of claims for eligible expenses incurred until the date participation terminated.

In addition, the Employer may terminate an individual's participation in the Plan for cause, which includes a termination for fraud or misrepresentation in an application for enrollment or claim for benefits. The rules described above shall also apply to an individual whose participation has terminated for cause.

3.7 Continuation Coverage

If an individual participating in the Medical Reimbursement Account goes on a military leave of absence, the Employer shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) with respect to the Plan. USERRA provides rights to continue participation in the Medical Reimbursement Account during a military leave of absence.

During any calendar year following a calendar year in which the Employer had employed 20 or more Employees (including part-time Employees who are counted as a fraction of a full-time Employee) during at least 50% of the business days in the year, an individual whose participation in the Plan terminates under section 3.6 has the option of continuing to participate in the Medical Reimbursement Program under COBRA. If an individual is eligible to elect COBRA with respect to the Medical Reimbursement Program, the individual shall be provided with a notice describing that right within the time period required by COBRA. If the individual elects COBRA, the individual may continue participation by timely making after-tax contributions on a monthly basis. The monthly after-tax contributions must be in an amount equal to the amount that was allocated to the individual's Account each month before the date participation terminated, or such larger amounts as may be permitted by the Code.

This option of continuing to participate in the Medical Reimbursement Program is available to the extent required by and for the period set forth in COBRA and U.S. Department of Treasury Regulations. An individual must pay after-tax contributions for a month by the first day of that month, with a 30-day grace period for timely payment. The Plan Administrator shall terminate the individual's participation if he does not make contributions on a timely basis.

If an individual does not elect to continue to participate in the Medical Reimbursement Program under this section, or the Plan Administrator terminates the individual's participation for failing to timely make after-tax contributions, any amount remaining in the individual's Medical Reimbursement Account after paying eligible expenses incurred while the individual was a Participant shall be forfeited.

3.8 Limit on Subsequent Participation

Notwithstanding any other provision of the Plan, a special participation rule applies in the following situation:

(a) The Participant applies Compensation reductions to purchase coverage under the Employer's Benefit Program(s) or to obtain the before-tax reimbursement of eligible expenses under the Medical Reimbursement Program or Dependent Care Reimbursement Program.

(b) The Participant separates from service with the Employer.

(c) The Participant is rehired and again becomes eligible for coverage within 30 days of separation of service and during the same Plan Year.

In this situation, the Participant may reinstate a prior Election with respect to accident and health coverage and make payment by Compensation reductions. However, the Participant may not use

Compensation reductions to pay the cost of accident and health coverage that is not identical to the Participant's prior Election until the first day of the first Plan Year following the Plan Year in which employment with the Employer was terminated. However, the Participant may make payment for such latter coverage by after-tax contributions. If such a Participant is rehired more than 30 days after separation from service and again becomes eligible for coverage, the Participant will be treated as a newly hired Employee.

3.9 Special Rules for Participants Taking FMLA Leave

The FMLA provisions of the Plan apply during any calendar year when the Employer employs 50 or more Employees (including part-time Employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible Participants (i.e., those whom the Employer has employed for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the FMLA leave). Notwithstanding any other provision of the Plan, the following special rules apply where the Employer is subject to FMLA and a Participant takes an FMLA leave:

(a) The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if a Participant takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA leave is 26 weeks per 12-month period.

(b) If the Participant had elected coverage under an Employer Benefit Program providing group health, dental, or vision benefits, the Participant may revoke that election upon taking an FMLA leave for the remainder of the Plan Year.

(c) If the Participant does not revoke an election under an Employer Benefit Program providing group health, dental, or vision benefits upon taking an FMLA leave, the Participant shall continue to be responsible to pay the required cost of coverage during the FMLA leave. The Participant's required cost of coverage shall be payable as follows:

(i) Paid Portion of FMLA Leave. With respect to the paid portion of the FMLA leave, the Participant shall continue to pay the required cost of coverage in the same manner as immediately before taking the FMLA leave–on a before-tax Compensation-reduction basis under the Plan. For this purpose, a leave is "paid" during any portion of the leave in which the Participant is receiving continued salary or hourly wages, payment for unused vacation or sick time, or any self-insured short-term disability benefits from the Employer.

(ii) Unpaid Portion of FMLA Leave. With respect to the unpaid portion of an FMLA leave, the Participant has the following options:

(A) Prepay. The Participant may prepay the required cost of coverage before the commencement of the FMLA leave on a before-tax Compensation-reduction basis under the Plan to the extent the Participant will receive Compensation before the FMLA leave.

However, prepayment on a before-tax Compensation-reduction basis can only be made for the period ending on the last day of the FMLA leave or the last day of the Plan Year during the FMLA leave, if earlier. Alternatively, the Participant may prepay on an after-tax basis.

(B) Pay-As-You-Go. The Participant may pay the required cost of coverage on an ongoing after-tax basis, with payments due on the same schedule as that required for qualified beneficiaries under COBRA.

(C) Catch-Up. The Employer and the Participant may agree in advance that the Employer will advance the Participant's required contributions during the FMLA leave. If this arrangement occurs, the Participant must repay the advanced amounts when the Participant returns from the FMLA leave, using pre-tax Compensation reductions, after-tax payments, or both. When a Participant fails to pay the required cost of coverage while on an FMLA leave, the Employer may recoup the shortfall upon the Participant's return from the FMLA leave under this catch-up option, even if the Employer and the Participant do not agree to this arrangement in advance.

(d) If the Participant fails to timely pay the required cost of coverage under an Employer Benefit Program providing group health, dental, or vision benefits in accordance with U.S. Department of Labor regulations issued pursuant to FMLA and the Employer's FMLA policy, the Employer may terminate the Participant's coverage under the Benefit Programs in accordance with U.S. Department of Labor regulations issued pursuant to FMLA and the Employer's FMLA policy. If the Employer chooses to continue coverage for a Participant who fails to make the required payments while on FMLA leave, the Employer shall be entitled to recoup those payments from the Participant after the FMLA leave to the extent permitted by U.S. Department of Labor regulations issued pursuant to FMLA and the Employer's FMLA policy.

(e) Upon return from the FMLA leave, a Participant may elect to be reinstated for coverage under a Benefit Program providing group health, dental, or vision benefits if coverage terminated while on the FMLA leave either by revocation or nonpayment of required costs. However, reinstatement shall be automatic if the Employer requires automatic reinstatement for Employees who return from non-FMLA unpaid leaves of absence. Upon reinstatement, the Participant's health, dental, or vision coverage shall be on the same basis as immediately before the FMLA leave. Thus, for example, the reinstatement must be made immediately, with no waiting period.

(f) A Participant on an FMLA leave has the same Election rights as an actively working Participant during an Open Enrollment Period and in the event the Employer offers a new or significantly improved benefit or coverage option during a Plan Year.

(g) If the Participant is entitled to receive an additional amount for waiving health coverage and takes an unpaid FMLA leave, the Participant shall not be entitled to this additional amount during the unpaid leave.

(h) For purposes of this section, any reference to the Employer's Benefit Programs providing group health, dental, or vision benefits shall also include the Participant's Account under the Medical Reimbursement Program. The rules contained in this section shall separately apply to the Participant's Account in the Medical Reimbursement Program. In addition, if the Participant's coverage under the Medical Reimbursement Program is terminated for any reason while the Participant is on an FMLA leave, the Participant is not entitled to receive reimbursement for claims incurred during the period when the coverage is terminated. Further, upon return from the FMLA leave, if the Participant elects to be reinstated in the Medical Reimbursement Account, the Participant's coverage for the remainder of the Plan Year shall be equal to one of the following: (i) the Participant's Election for the Plan Year reduced by prior reimbursements; or (ii) the Participant's Election for the Plan Year prorated for the period during the FMLA leave for which no contributions were made and reduced by prior reimbursements.

(i) If the Participant does not return to work at the end of the FMLA leave, his participation shall terminate, unless the Participant has been granted an additional non-FMLA approved leave of absence by the Employer at the end of the FMLA leave, in which case the terms of the next section shall apply.

3.10 Special Rules for Participants Taking Non-FMLA Leaves

The rules contained in section 3.9 shall also apply to a Participant who takes a non-FMLA approved leave of absence.

ARTICLE IV: BENEFITS

4.1 Component Programs

A Participant may receive full Compensation for any Plan Year in cash or elect to have the Employer reduce his Compensation and credit the amount of the reduction toward the cost of coverage under the following Component Programs:

(a) The **Berrien Regional Education Service Agency** Pre-Tax Premium Payment Program (including the SHOP Exchange).

(b) The **Berrien Regional Education Service Agency** Medical Reimbursement Program.

(c) The **Berrien Regional Education Service Agency** Dependent Care Reimbursement Program.

The type and amount of benefits available, eligibility requirements, and other terms and conditions of each Component Program are more fully described in articles VI, VII, and VIII of this Plan document.

ARTICLE V: CONTRIBUTIONS AND FUNDING

5.1 Contributions

A Participant may elect to reduce his Compensation and have the Employer contribute the amount of the reduction to purchase Benefits under the Plan. This reduction of Compensation is referred to as an elective contribution. The Employer shall deduct a Participant's elective contribution in substantially equal installments from the Participant's Compensation during a Plan Year. If a Participant waives coverage under a Benefit Program, the Employer may contribute an additional amount to the Plan on the Participant's behalf, as described in section 6.1.

5.2 Funding

The Employer shall credit all contributions to the applicable Component Program within the time required to qualify for a deduction under the Code.

(a) Insured/Prepaid Benefits. The Employer shall transmit contributions for insured/prepaid Benefits to the appropriate Benefit Provider as soon as administratively feasible and in no event later than the deadline required by law.

(b) Non-Insured Benefits. The Employer shall hold contributions for non-insured or non-prepaid Benefits with its general assets or in a trust if required by the Code or if the Employer so chooses.

5.3 Forfeitures

Any amount credited to the Plan not used to provide Benefits under the Plan for the Plan Year credited shall be forfeited. A credit balance may not be carried forward to a later Plan Year and shall not be available to the Participant in any other form, except as provided below.

(a) Mandatory Application of Forfeitures. The Plan Administrator shall apply forfeitures to offset the reasonable administrative expenses of the Plan.

(b) Discretionary Application of Forfeitures. After the mandatory application of forfeitures described in subsection (a), the Plan Administrator may, at its discretion, retain any forfeitures remaining at the end of the Plan Year. The Plan Administrator may also use any forfeitures remaining at the end of the Plan Year to reduce elective contributions for the Plan in the following Plan Year on a reasonable and uniform basis or distribute the forfeitures on a per capita basis to all persons who were Participants in the Plan on the last day of the Plan Year.

5.4 Administrative Expenses

The Plan Administrator may require Participants' Compensation reductions to pay for the reasonable administrative expenses of the Plan.

ARTICLE VI: PRE-TAX PREMIUM PAYMENT PROGRAM

6.1 Intent and Purpose

The **Berrien Regional Education Service Agency Pre-Tax Premium Payment Program** (the "Pre-Tax Premium Payment Program") is established as a Component Program under the Plan. It is intended that the Pre-Tax Premium Payment Program shall be construed and operated in a manner to cause it to qualify under Code Section 125 and in a manner not inconsistent with the Plan. The purpose of the Pre-Tax Premium Payment Program, with respect to each of the Employer's Benefit Programs covered by the Pre-Tax Premium Payment Program, is to enable a Participant to do the following:

(a) General Rule.

(i) Elect Coverage. A Participant may elect coverage under the Benefit Program and pay any required Premiums with Compensation reductions.

(ii) Waive Coverage. A Participant may waive coverage under the Benefit Program and receive his entire Compensation through the Employer's payroll system. If coverage is waived, the Employer may provide the Participant with an additional amount that the Participant may use to purchase Benefits under the Plan or may receive as additional Compensation through the Employer's payroll system. Any additional amount for waiving coverage shall be based on a nondiscriminatory formula determined by the Employer.

(b) Special Rule – Pay COBRA Premiums. A Participant or a current or former Employee who is not a Participant but who is receiving Compensation from Employer may elect to pay COBRA premiums for group health coverage on a Compensation-reductions basis in the following circumstances:

(i) If the Employee continues to be employed by Employer but has a change in employment status and becomes ineligible for health coverage under the Benefit Program, the Employee may elect to pay COBRA premiums for Employer-provided health coverage on a Compensation-reductions basis under the Plan.

(ii) If an Employee terminates employment and receives severance pay from Employer, the former Employee may elect to pay COBRA premiums for Employer-provided health coverage on a Compensation-reductions basis under the Plan from the severance pay.

(iii) If a newly hired Employee is eligible to participate in the Plan or will become eligible upon completing any applicable waiting period, the Employee may elect to pay COBRA premiums under a former Employer's group health plan on a Compensation-reductions basis under the Plan.

6.2 Eligibility and Participation

An Employee shall be eligible to participate in the Pre-Tax Premium Payment Program on the first day that the Employee becomes obligated to pay a Premium for coverage.

6.3 Definition of Premium

For purposes of the Pre-Tax Premium Payment Program, "Premium" means the amount that the Employer requires an Employee to contribute for the coverage of the Employee and any eligible Spouse and Dependents under a Benefit Program. "Premium" also means the amount that an Employee is required to contribute for the coverage of the Employee and any eligible Spouse and Dependents under any welfare benefit plan not provided by the Employer, provided that the coverage constitutes a Qualified Benefit.

6.4 Election of Coverage

If a Participant elects coverage under a Benefit Program, the Participant's Election shall not become final until the Benefit Provider has accepted the Participant's application for coverage.

6.5 Period of Coverage

Compensation reductions during a Plan Year shall be applied to pay Premiums for coverage for that Plan Year. However, Compensation reductions from the last month of one Plan Year may be applied to pay Premiums for coverage during the first month of the immediately following Plan Year, if done on a uniform and consistent basis with respect to Participants.

6.6 Maximum Contribution

The Maximum Contribution for any Participant in the Pre-Tax Premium Payment Program for the Plan Year shall be the additional Compensation, if any, for waiving coverage under the Benefit Program(s) plus the Participant's maximum Compensation reductions for the Plan Year to pay Premiums for the most expensive coverage for which the Participant is eligible. The Maximum Contribution for coverage shall automatically change when the applicable Premium changes.

6.7 Claims

Any claim for benefits under a Benefit Program or welfare benefit plan shall be filed with the Benefit Provider. The claim shall be filed on the form and shall include any proof of claim required by the Benefit Provider. If the Benefit Provider denies a claim, the Participant or beneficiary shall follow the claims review procedure of the Benefit Provider. Claims with respect to the payment of Premiums under this Pre-Tax Premium Payment Program shall be filed with the Plan Administrator as provided in the Claims Procedure article.

ARTICLE VII: MEDICAL REIMBURSEMENT PROGRAM

7.1 Intent and Purpose

The Employer has established the **Berrien Regional Education Service Agency Medical Reimbursement Program** (the "Medical Reimbursement Program") to enable a Participant to obtain the before-tax reimbursement of Qualifying Medical Expenses. It is intended to be interpreted and operated in a manner to cause it to qualify under Code Section 105(b) and in a manner not inconsistent with Code Section 125. The Medical Reimbursement Program is set forth in this article.

7.2 Eligibility and Participation

Only Employees who are eligible for Employer-provided group medical coverage under an Employer-provided Benefit Program are eligible to participate in the Medical Reimbursement Program. An eligible Employee shall become a Participant on the first day that the Participant is eligible to participate in medical coverage under an Employer-provided Benefit Program.

7.3 Description of Benefits

Benefits under the Medical Reimbursement Program shall consist of the reimbursement of Qualifying Medical Expenses in an amount not to exceed the Maximum Contribution.

(a) Qualifying Medical Expense. For purposes of the Medical Reimbursement Program, "Qualifying Medical Expense" means an expense incurred for Medical Care as defined in Code Section 213 and subsection (b) below. A Qualifying Medical Expense is incurred by a Participant, Spouse, or Dependent, but only to the extent the expense is incurred during a Plan Year. Qualifying Medical Expenses are deemed to be incurred when services are rendered or supplies are provided, not when billed or paid. However, notwithstanding this general rule, orthodontia services may be reimbursed before the services are provided but only to the extent that the Participant has actually made payment in advance of the orthodontia services in order to receive the services. Such orthodontia services are deemed to be incurred when the Participant makes the advance payment.

(b) Medical Care. Subject to the exclusions in subsection (c) below, for purposes of the Medical Reimbursement Program, "Medical Care" means amounts paid on behalf of a Participant or a Dependent for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. The term includes transportation primarily for and essential to medical care. The term includes, but is not limited to, the following:

(i) Acupuncture. Acupuncture.

(ii) Ambulance Service and Other Travel Costs to Obtain Health Care. If the Participant uses a personal vehicle, expenses for gas and oil may be reimbursable or, alternatively, the Participant may submit a claim for the

maximum amount per mile prescribed by the IRS. Parking and tolls are also reimbursable under either method.

(iii) Body Scans. Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors, and on-site health fairs that measure health indicators such as blood pressure and cholesterol.

(iv) Chemical Dependency. Therapeutic treatment for chemical dependency, including meals and lodging if they are necessary for the treatment.

(v) Cord Blood Storage. Cord blood storage for a child born with a medical condition that may require cord blood in the future, but not if storing is just in case of a future need.

(vi) Counseling. Psychoanalysis, psychiatric therapy, learning disability counseling by a licensed professional, inpatient care and treatment (including special schooling if necessary for a mental or physical handicap), and services provided by a licensed psychologist.

(vii) Deductibles, Co-payments, and Non-Covered Expenses. Expenses covered, but not paid for, by a group health plan maintained by the Employer, such as the amount paid before benefits begin (the deductible), the percentage of charges not paid by the plan (co-payment), and expenses over the maximum benefit amounts.

(viii) Dental. Dental expenses, including preventive, diagnostic, orthodontic, and therapeutic care.

(ix) Examinations. Physical examinations.

(x) Hearing. Hearing expenses, including examinations and hearing aids.

(xi) Massage Therapy. Massage therapy prescribed by a physician to treat a medical condition.

(xii) Medical Equipment. Special medical equipment, bought or rented, because of a medical problem, such as wheelchairs, crutches, and orthopedic shoes, or for the repair or replacement of prosthetic devices due to normal wear and tear.

(xiii) Other Deductible Expenses. Other medical expenses qualifying as legitimate deductions for federal income tax purposes, subject to the approval of the Plan Administrator.

(xiv) Over-the-Counter Drugs and Medicines. Over-the-counter drugs and medicines specifically prescribed by a physician, and insulin.

(xv) Prescription Drugs. Medicine or other drugs prescribed by a doctor, including vitamins and birth control pills and devices.

(xvi) Teeth Whitening. Teeth whitening to correct discoloration caused by disease, birth defect, or injury.

(xvii) Vision. Vision expenses including examinations, eyeglasses, contact lenses, LASIK (laser) eye surgery, and seeing-eye dogs.

(xviii) Weight Loss. Expenses for weight-loss programs as treatment for obesity, including fees to join the program, but not food.

(c) Excluded Expenses. Medical Care does not include the following expenses:

(i) Health Plan Premiums. Premiums paid for health plan coverage, including premiums paid for any group health plan maintained by any employer of the Participant's Dependent.

(ii) Long-term Care Expenses. Long-term care expenses and premiums for long-term care insurance.

(iii) Non-prescription Drugs and Medicines. All non-prescription drugs and medicines unless specifically prescribed by a physician or if the drug is insulin.

(iv) Unnecessary Cosmetic Surgery. Expenses incurred for cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. For purposes of this paragraph, the term "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

7.4 Nondiscrimination

The Medical Reimbursement Program shall comply with the applicable nondiscrimination requirements under Code Section 105(h). Code Section 105(h) prohibits discrimination in eligibility or benefits in favor of highly compensated individuals. A highly compensated individual for this purpose is one of the five highest paid officers of the Employer, a 10% or greater shareholder of the Employer, or an individual who is among the highest paid 25% of Employees.

7.5 Maximum Contribution

The Employer may, in its discretion, establish the Maximum Contribution that any Participant may make under the Medical Reimbursement Program in any Plan Year and may change this amount annually. Employees who are not Participants at the beginning of a Plan Year shall be entitled to a pro rata portion of the Maximum Contribution. The Employer may, in its discretion, establish a minimum annual contribution.

Pursuant to Code Section 125(i)(1), a Participant may allocate no more than $2,600 in Compensation reductions to the Participant's Medical Reimbursement Account for a Plan Year (the "Dollar Limit"). The Dollar Limit may be increased in subsequent Plan years for changes in the cost-of-living in accordance with Code Section 125(i)(1). The Dollar Limit shall be prorated during any short Plan Year in accordance with IRS Notice 2012-40.

7.6 Medical Reimbursement Account

For each Plan Year, the Employer shall establish and maintain on its books a Medical Reimbursement Account for each Participant to which contributions shall be credited. Amounts shall be debited from the Medical Reimbursement Account from time to time in the amount of reimbursements of Qualifying Medical Expenses. In accordance with the uniform coverage rule, the amount available to the Participant for reimbursement of Qualifying Medical Expenses shall, at all times during the Plan Year, be equal to the entire amount elected by the Participant for the Plan Year less any previous reimbursements made during the Plan Year.

7.7 Forfeiture of Amounts

Notwithstanding any other provision of the Plan, if a Participant has an unused balance in his Medical Reimbursement Account for a Plan Year, the balance (up to a maximum of $500), may be carried over to the subsequent Plan Year for reimbursement of Qualifying Medical Expenses incurred during the subsequent Plan Year. However, the carryover is available to a Participant for a subsequent Plan Year only if the Participant has elected to contribute pre-tax Compensation reductions to the Participant's Medical Reimbursement Account for that subsequent Plan Year. The carryover shall be determined in accordance with IRS Notice 2013-71.

The Plan shall treat reimbursement of all claims for Qualifying Medical Expenses incurred during the current Plan Year as reimbursed first from unused amounts credited to the Participant's Medical Reimbursement Account for the current Plan Year and only after exhausting the current Plan Year amounts, as then reimbursed from unused amounts carried over from the preceding Plan Year. Any unused amounts from the prior Plan Year that are used to reimburse a current Plan Year expense shall be available immediately after the claims submission period described in section 7.8 (i.e., 90 days after the end of the Plan Year), must be counted against the permitted carryover of up to $500, and cannot exceed the permitted carryover.

Except for the $500 carryover, if any balance remains in a Participant's Medical Reimbursement Account for a Plan Year, after all eligible reimbursements have been made, the balance shall be forfeited by the Participant. The balance shall not be carried over to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year.

7.8 Claims for Reimbursement

Claims for reimbursement under this Program are administered in one or both of the following methods:

(a) Traditional Method. A Participant under this Program may file any claim for reimbursement of Qualifying Medical Expenses incurred during a Plan Year with the Plan Administrator. The claim must be accompanied by an invoice, receipt, or

other written statement from the provider or other independent third party constituting satisfactory proof that a Medical Care expense has been incurred, including the amount of the expense, the date the expense was incurred, and the name and address of the Medical Care provider. The Participant must also provide a written statement that the Medical Care expense has not been paid or reimbursed by, nor will the Participant seek payment or reimbursement by, any other employer-sponsored plan; any federal, state, or other governmental plan or program; or any other source. The Participant must apply for reimbursement no later than 90 days following the last day of the Plan Year. Further, the Participant who terminates employment and participation in the Plan before the end of a Plan Year must file all claims for reimbursement no later than 90 days from the date of termination.

(b) Debit Card Method. The Plan Administrator may issue a debit card for the express purpose of reimbursing Qualifying Medical Expenses incurred by a Participant under this Program. The Participant will receive the debit card upon agreeing to any cardholder agreement, terms and conditions of use, or other documents required by the debit card issuer or the Plan Administrator (collectively, the "Debit Card Agreement"). To the extent the Debit Card Agreement conflicts in any way with the terms of the Plan, the Debit Card Agreement shall control to the extent it relates to the debit card aspect of the Plan.

The debit card shall be turned off and unavailable upon the Participant's termination of employment. If a Participant receives reimbursement without adequate substantiation or terminates participation after receiving reimbursements from his Medical Reimbursement Account for the Plan Year that exceed the amount elected to be contributed for the Plan Year, and the individual does not promptly repay the excess, the Employer may take any permissible action against the individual to recover the excess.

7.9 Limits on Claims

Reimbursement shall be limited to the amount of Benefits the Participant elected under the Medical Reimbursement Program. If, for any reason, aggregate reimbursements exceed the elected benefits, the Participant shall repay the excess to the Employer. The Employer may deduct the excess as an offset to any amount then owing to the Participant as salary, wages, or otherwise, to the extent permitted by law. The Plan Administrator may, in its discretion, establish a minimum claim requirement, to the extent permitted by law.

7.10 Reimbursement

A Participant shall be notified of the approval or denial of the claim as provided in the Claims Procedure article, except that under the Medical Reimbursement Program, claims shall be paid at least monthly. When reimbursement is made, the Plan Administrator shall debit the Participant's Medical Reimbursement Account in the amount of the reimbursement.

7.11 HIPAA – Special Enrollment Rights

For each Plan Year, a Participant's Medical Reimbursement Account will be an excepted benefit that is not subject to the special enrollment rights rules of HIPAA if all three of the following requirements are satisfied:

(a) The maximum benefit payable by the Employer under the Medical Reimbursement Account for the Plan Year does not exceed two times the Participant's Compensation reduction Election under the Medical Reimbursement Account for the Plan Year (or, if greater, the amount of the Participant's Compensation reduction Election under the Medical Reimbursement Account for the Plan Year plus $500). Any Employer credits or benefit dollars that the Participant may elect to receive as additional Compensation are disregarded and considered Employee (vs. Employer) Contributions for this purpose.

(b) The Participant is eligible for Employer-provided group health coverage other than the Medical Reimbursement Account for the Plan Year.

(c) The other Employer-provided group health coverage is not limited to benefits that are excepted benefits under HIPAA.

If a Participant's Medical Reimbursement Account does not qualify as an excepted benefit for a Plan Year, the Plan shall comply with HIPAA with respect to the Participant's Medical Reimbursement Account for the Plan Year (e.g., by granting special enrollment rights regarding the Medical Reimbursement Account).

7.12 Compliance with HIPAA Privacy and Security Rules

(a) Permitted and Required Uses and Disclosures of Protected Health Information (PHI). Subject to obtaining written certification pursuant to the Certification of Plan Sponsor section below, the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor does not use or disclose PHI except for the following purposes:

(i) To perform Administrative Functions for the Plan.

(ii) To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 CFR §164.504(f).

(b) Conditions of Disclosure. The Plan Sponsor agrees to the following stipulations in regard to any PHI:

(i) To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(ii) To ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(iii) To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(iv) To report to the Plan any known use or disclosure of the information that is inconsistent with the uses or disclosures permitted.

(v) To make a Participant's PHI available upon request for access in accordance with 45 CFR § 164.524.

(vi) To make a Participant's PHI available upon request for an amendment and incorporate any amendments to that PHI in accordance with 45 CFR § 164.526.

(vii) To make available the information required to provide an accounting of disclosures of PHI to a Participant upon request in accordance with 45 CFR § 164.528.

(viii) To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.

(ix) To return or destroy all PHI received from the Plan if the PHI is still maintained in any form, if feasible, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made; if such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(x) To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth in the applicable provision below are followed.

On the date the Plan is required to be compliant with the HIPAA security standards, the Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate

security measures to protect the information. Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

(c) Certification of Plan Sponsor. The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii) and that the Plan Sponsor agrees to the conditions of disclosure set forth in the previous section.

(d) Permitted Uses and Disclosures of Summary Health Information. The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only to modify, amend, or terminate the Plan.

(e) Adequate Separation between the Plan and the Plan Sponsor. The Plan Sponsor will provide access to PHI to the employees or classes of employees listed in its HIPAA privacy policies and procedures. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule on the required effective date, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

(f) Disclosure of Certain Enrollment Information. Pursuant to 45 CFR § 164.504(f)(1)(iii), the Plan may disclose information on whether an individual is enrolled in or has terminated from the Plan to the Plan Sponsor.

(g) Other Disclosures and Uses of PHI. With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

(h) Hybrid Entity. This subsection applies to the extent the Plan provides any non-health benefits such as, but not limited to, Dependent Care Reimbursement Program benefits, which shall be considered "non-covered functions." The Plan is a separate legal entity whose business activities include the functions covered by the HIPAA privacy and security rules and non-covered functions. As a result, the Plan is a "hybrid entity" as that term is defined in HIPAA. The Plan's covered functions are its health benefits ("health care component"). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall be a covered entity under the HIPAA privacy and security rules only with respect to the health care component (the Medical Reimbursement Program) of the Plan.

(i) Participant Notification. Participants shall be notified of the Plan Sponsor's compliance with the HIPAA privacy rules in the Notice of Privacy Practices.

ARTICLE VIII: DEPENDENT CARE REIMBURSEMENT PROGRAM

8.1 Intent and Purpose

The Employer has established the **Berrien Regional Education Service Agency Dependent Care Reimbursement Program** (the "Dependent Care Reimbursement Program") to enable a Participant to obtain the before-tax reimbursement of Dependent Care Expenses. It is intended to be construed and operated in a manner to cause it to qualify as a dependent care assistance program under Code Section 129 and in a manner not inconsistent with Code Section 125. The Dependent Care Reimbursement Program is set forth in this article.

8.2 Eligibility and Participation

Only Employees who are eligible for Employer-provided group medical coverage under an Employer-provided Benefit Program are eligible to participate in the Dependent Care Reimbursement Program. An eligible Employee shall become a Participant on the first day that the Participant is eligible to participate in medical coverage under an Employer-provided Benefit Program.

8.3 Definitions and Description of Benefits

Benefits under the Dependent Care Reimbursement Program shall consist of the reimbursement of Dependent Care Expenses in an amount not to exceed the Maximum Contribution. For purposes of the Dependent Care Reimbursement Program, the following terms have the meanings set forth below.

(a) Dependent. "Dependent" means an individual who is a Qualifying Child or a Qualifying Relative of a Participant.

(b) Dependent Care Expense. "Dependent Care Expense" means any expense incurred during a Plan Year for the following services to enable the Participant to be gainfully employed. Dependent Care Expenses are deemed to be incurred when dependent care services are rendered, not when billed or paid.

(i) Services Provided in the Home. Services inside the Participant's household for the care of a Dependent and for related household services.

(i) Services Provided Outside the Home. Services outside the Participant's household for the care of a Qualifying Child who is under age 13 or for a Spouse or Dependent (regardless of the Dependent's age) who has a Total Disability and who regularly spends at least eight hours each day in the Participant's household.

Dependent Care Expenses do not include any amount paid for services at a camp where the Dependent stays overnight.

(c) Qualifying Child. "Qualifying Child" means an individual who is younger than the Participant and who meets all of the following requirements:

(i) Child. The individual is the natural child, adopted child (including by legal adoption and placement in anticipation of adoption), stepchild, or foster child of the Participant; a descendant of such a child; a brother, sister, stepbrother, or stepsister of the Participant; or a descendant of any such relative.

(ii) Financial Support. The individual has not provided over half of the individual's own financial support for the year.

(iii) No Joint Tax Return. The individual has not filed a joint tax return (other than for a claim of refund) with the individual's spouse for the year.

(iv) Principal Residence. The individual has the same principal place of residence as the Participant for more than half of the year, disregarding certain temporary absences.

(v) Special Rule Relating to Two or More Individuals Claiming a Qualifying Child. A child cannot be treated as a Qualifying Child, for purposes of the Plan, with respect to more than one individual. The following rules determine who may claim a child as a Qualifying Child, for purposes of the Plan, if two individuals claim the child as a Qualifying Child for the year for income tax purposes:

(A) One Parent and One Non-Parent. A child that is claimed as a Qualifying Child for tax purposes by two individuals (where one is a parent and one is a non-parent) for a year shall be treated as the Qualifying Child of the individual who is the parent.

(B) Neither is a Parent. A child that is claimed as a Qualifying Child for tax purposes by two individuals (where neither is a parent) for a year shall be treated as the Qualifying Child of the individual with the highest adjusted gross income for the year, provided that if a parent could claim the child as a Qualifying Child but does not do so, the claiming individual who is not a parent has a higher adjusted gross income than any parent.

(C) Parents Filing Separate Tax Returns. Except as provided in the next paragraph, a child of parents who do not file a joint tax return shall be treated as the Qualifying Child of the parent with whom the child resides for the longer period during the year. If the child resides with both parents for the same amount of time during the year, the child shall be treated as the Qualifying Child of the parent with the highest adjusted gross income for the year.

(D) Divorced or Legally Separated Parents. A child of divorced or legally separated parents who is under the age of 13 or who has a Total Disability regardless of age shall be treated as a Qualifying Child of the custodial parent (the parent with whom the child shares the same principal residence for the greater portion of the year), even if the child is a Qualifying Child of the non-custodial parent for income tax purposes. The child cannot be treated as a Qualifying Child, for purposes of the Plan, with respect to more than one parent.

(d) Qualifying Individual. "Qualifying Individual" means any of the following:

(i) A Dependent who is a Qualifying Child and who is under the age of 13.

(ii) A Dependent who has a Total Disability regardless of age and who has the same principal residence as the Participant for more than half of the year.

(iii) A Spouse of the Participant who has a Total Disability and who has the same principal residence as the Participant for more than half of the year.

The status of a person as a Qualifying Individual is determined on a day-to-day basis.

(e) Qualifying Relative. "Qualifying Relative" means an individual who meets all of the following requirements:

(i) The individual bears a relationship to the Participant within the meaning of Code Section 152(d)(2).

(ii) The Participant provides over half of the individual's financial support for the year.

(iii) The individual is not a Qualifying Child of the Participant or any other person for the year.

(f) Total Disability. "Total Disability" means a physical or mental condition that makes an individual incapable of taking care of personal hygienic or nutritional needs or causes the individual to require the full-time attention of another person for personal safety or the safety of others.

8.4 Special Nondiscrimination Rules

The Dependent Care Reimbursement Program shall be subject to applicable nondiscrimination requirements under Code Section 129(d), which are described in this section.

(a) Contributions or Benefits. The contributions or benefits provided under the Dependent Care Reimbursement Program shall not discriminate in favor of Highly Compensated Employees or their Dependents.

(b) Eligibility. The Dependent Care Reimbursement Program shall benefit Employees who qualify under a classification set up by the Employer that does not discriminate in favor of Highly Compensated Employees or their Dependents. Any Employees excluded from participation who are under age 21 and have completed one year of continuous employment may be excluded for purposes of this nondiscrimination test, to the extent permitted under Code Section 129(d)(9)(A).

(c) Fifty-five Percent Average Benefits Test. The average benefit provided to all the Participants who are not Highly Compensated Employees under all of the Employer's dependent care assistance plans must be at least 55% of the average benefit provided to all the Participants who are Highly Compensated Employees under all of the Employer's dependent care assistance plans, as provided under Code Section 129(d)(8).

Any Participants with annual Compensation of less than $25,000 may either be included or excluded for purposes of the 55% average benefits test. Further, any Participants who are under age 21 and have completed one year of continuous employment may be excluded for purposes of the 55% average benefits test, to the extent permitted under Code Section 129(d)(9)(A).

The Employer shall conduct periodic testing immediately before or during each Plan Year to determine if the 55% average benefits test is being satisfied. As of the first day during the Plan Year the Employer's testing indicates that the 55% average benefits test shall not be satisfied, the Employer shall reduce the amounts allocated to the Dependent Care Reimbursement Program on behalf of Participants who are Highly Compensated Employees to the extent necessary to satisfy the 55% average benefits test or all or a portion of these amounts may be treated as taxable income.

8.5 Maximum Contribution

The Maximum Contribution that any Participant may make under the Dependent Care Reimbursement Program in any taxable year of the Participant shall be equal to the smallest of the following:

(a) Dollar Limitation. $5,000 ($2,500 in the case of a married Participant who files a separate federal income tax return for the taxable year) or any such different amount specified in Code Section 129(d)(8)(B).

(b) Participant's Earned Income. The Participant's Earned Income for the taxable year.

(c) Spouse's Earned Income. The Earned Income for the taxable year of the Participant's Spouse (if married on the last day of the taxable year).

8.6 Earned Income

For purposes of section 8.6, "Earned Income" means all income derived from wages, salaries, tips, and other compensation (such as disability benefits), but excluding any amount received under the Dependent Care Reimbursement Program or any other dependent care assistance plan pursuant to Code Section 129 as a pension or annuity or as unemployment or workers' compensation.

(a) Earned Income of Student. A Spouse who is a full-time student at a college or university shall be deemed to have Earned Income of not less than $250 if the Participant has one Dependent, or $500 if the Participant has two or more Dependents, for each month that the Spouse is a full-time student.

(b) Earned Income of Disabled Spouse. A Spouse who has a Total Disability shall be deemed to have Earned Income of not less than $250 if the Participant has one Dependent, or $500 if the Participant has two or more Dependents, for each month that the Spouse has a Total Disability.

8.7 Dependent Care Reimbursement Account

For each Plan Year, the Employer shall establish and maintain on its books a Dependent Care Reimbursement Account for each Participant to which contributions shall be credited. Amounts shall be debited from the Dependent Care Reimbursement Account from time to time in the amount of reimbursements of Dependent Care Expenses.

8.8 Forfeiture of Amounts

Any amount credited to a Dependent Care Reimbursement Account for a Plan Year that is not used to reimburse Dependent Care Expenses incurred during that Plan Year shall be forfeited.

8.9 Claims for Reimbursement

Claims for reimbursement under this Program are administered in one or both of the following methods:

(a) Traditional Method. A Participant under this Program may file any claim for reimbursement of Dependent Care Expenses incurred during a Plan Year with the Plan Administrator. The claim must be accompanied by an invoice, receipt, or other written statement from the provider or other independent third party constituting satisfactory proof that a Dependent Care Expense has been incurred, including the amount of the expense, the date the expense was incurred, and the name and address of the person or entity to which the Dependent Care Expense was paid. In addition, the Participant must provide the taxpayer identification number of the entity or social security number of the person providing dependent care services, or certification that the Participant has obtained this information. If the entity providing dependent care services is a tax-exempt organization described in Code Section 501(c)(3), the Participant must indicate that the entity is tax-exempt, rather than providing its taxpayer identification number. The Participant must also provide a written statement that the Dependent Care

Expense has not been paid or reimbursed by, or is not payable or reimbursable under, any other employer-sponsored plan; any federal, state, or other governmental plan or program; or any other source. The Participant must apply for reimbursement no later than 90 days following the last day of the Plan Year. Further, the Participant who terminates employment and participation in the Plan before the end of a Plan Year must file all claims for reimbursement no later than 90 days from the date of termination.

(b) Debit Card Method. The Plan Administrator may issue a debit card for the express purpose of reimbursing Dependent Care Expenses incurred by a Participant under this Program. The Participant will receive the debit card upon agreeing to any cardholder agreement, terms and conditions of use, or other documents required by the debit card issuer or the Plan Administrator (collectively, the "Debit Card Agreement"). To the extent the Debit Card Agreement conflicts in any way with the terms of the Plan, the Debit Card Agreement shall control to the extent it relates to the debit card aspect of the Plan.

8.10 Limits on Claims

Reimbursement shall be limited to the balance in the Participant's Dependent Care Reimbursement Account at the time of the claim. If, for any reason, aggregate reimbursements exceed the balance, the Participant shall repay the excess to the Employer. The Employer may deduct the excess as an offset to any amount then owing to the Participant as salary, wages, or otherwise to the extent permitted by law. The Plan Administrator may, in its discretion, establish a minimum claim requirement to the extent permitted by law.

8.11 Reimbursement

A Participant shall be notified of the approval or denial of the claim as provided in the Claims Procedure article, except that under the Dependent Care Reimbursement Program, claims shall be paid at least monthly. When reimbursement is made, the Plan Administrator shall debit the Participant's Dependent Care Reimbursement Account in the amount of the reimbursement.

8.12 Statement of Benefits

The Plan Administrator shall report to each Participant in writing by January 31 of each calendar year the amount allocated to the Participant's Dependent Care Reimbursement Account for the previous calendar year and the amount reimbursed to the Participant for Dependent Care Expenses under the Dependent Care Reimbursement Program during the previous calendar year.

ARTICLE IX: CLAIMS PROCEDURE

9.1 Payment or Reimbursement

In order to receive payment or reimbursement under a Component Program, a Participant (for purposes of this article called a Claimant) must submit the information required by the Plan Administrator, in accordance with the Component Program under which the payment or

reimbursement is sought. A Claimant shall submit a claim for payment or reimbursement to the Plan Administrator, who will evaluate the claim and notify the Claimant of the approval or disapproval, in accordance with the provisions of the applicable Component Program.

(a) Claims Evaluation. Except as may be provided in a Component Program, the Plan Administrator or Claim Administrator shall decide all claims no later than 90 days after the receipt of the claim, unless it requires an extension of time to process the claim owing to special circumstances. The Plan Administrator shall notify the Claimant in writing, before the termination of the initial 90-day period, of the special circumstances necessitating the extension and the date it expects to make a final decision (not later than 180 days after the date on which the claim was filed). The Plan Administrator shall notify the Claimant in writing whether the claim is granted or denied, in whole or in part. If the Plan Administrator does not notify the Claimant in writing of the claim decision or the need for an extension within 90 days after the receipt of the claim, the claim shall be deemed to be denied.

(b) Approval of Claim. Except as may be provided in a Component Program, if the Plan Administrator approves a claim, it shall issue payment as soon as administratively feasible.

(c) Denial of Claim. The Plan Administrator will provide the Claimant with written or electronic notification of a claim denial in whole or in part. The notification will contain the following: (i) the specific reasons for the denial; (ii) references to pertinent Plan provisions on which the denial is based; (iii) a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary; and (iv) the Claimant's rights to seek review of the denial and the procedure to follow in seeking review. The notice of claim denial shall be written in a manner comprehensible to the Claimant.

9.2 Review of Claim Denial

If the Plan Administrator denies a claim for payment or reimbursement, in whole or in part, the Claimant shall have the right to request that the Plan Administrator review the denial. If a Claimant fails to file a request for review in accordance with the procedures outlined below, the Claimant shall have no right to review or to bring an action in any court, and the denial of the claim shall become final and binding on all persons for all purposes.

(a) Claimant's Request for Review. The Claimant must file a written request for review with the Plan Administrator within 60 days after the date the written notice of claim denial was received. A Claimant (or the Claimant's duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Plan Administrator.

(b) Administrative Review. The Plan Administrator shall review the denial within 60 days after receiving a request for review and advise the Claimant in writing of the decision on review, unless it requires an extension of time to process the review owing to special circumstances. The Plan Administrator shall notify the Claimant

in writing, within the initial 60-day period, of the reasons for the extension and when it shall complete the review (provided that it shall complete the review within 120 days after the date the Claimant filed the request for review).

(c) Administrative Decision. The Plan Administrator will send the Claimant a written notice of the decision on review, which shall be written in a manner comprehensible to the Claimant and shall include specific reasons for the decision and references to Plan provisions upon which the decision is based.

9.3 Participant Indemnification

The Participant shall indemnify and reimburse the Employer and the Plan for any expense or cost incurred (including attorney fees) on account of the payment of a Benefit that should not have been paid or reimbursed.

9.4 Facility of Payment

A payment made under this section shall fully discharge the Plan Administrator from all future liability with respect to the payment.

(a) Anti-Escheat. If the Plan Administrator cannot locate a person entitled to payment, the amount shall be forfeited.

(b) Determinations. The Plan Administrator may act upon affidavits in making any determination. The Plan Administrator, in relying upon affidavits or having made a reasonable effort to locate any person entitled to payment, shall be authorized to direct payment to a successor beneficiary or another person. A person omitted from payment thereby shall have no rights on account of payments so made.

(c) Incapacity. If a person entitled to payment is legally, physically, or mentally incapable of receiving or acknowledging payment, the Plan Administrator may direct payment in any one or more of the following ways: directly to the person; to the person's legal representative; to a Spouse, child, or relative by blood or marriage of the person; to the person with whom the person resides; or by expending the payment directly for the benefit of the person. A payment made other than to the person shall be used for the person's exclusive benefit.

(d) Legal Representative. The Plan Administrator shall not be required to commence probate proceedings or secure the appointment of a legal representative.

9.5 No Interest

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

9.6 Escheat

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

ARTICLE X: ADMINISTRATION

10.1 Plan Administrator

The Plan Administrator is a named fiduciary for operation and management of the Plan and shall have the discretionary powers necessary to administer and meet its obligations under the Plan, including, without limitation, the following:

(a) Administrative Records. The responsibility to establish procedures for and supervise the establishment and maintenance of all records necessary and appropriate for the proper administration of the Plan.

(b) Administrative Rules. The responsibility to issue rules and regulations necessary for the proper conduct and administration of the Plan or the Component Programs and to change, alter, or amend such rules and regulations.

(c) Advisors. The responsibility to employ on behalf of the Plan (to the extent reasonably necessary for operation, administration, and management of the Plan) attorneys, actuaries, accountants, clerical employees, agents, or other persons.

(d) Appointment of Fiduciaries. The responsibility for appointing and removing Plan fiduciaries.

(e) Claim Administrator. In its discretion, the responsibility to appoint, suitably compensate, and remove the Claim Administrator for the Plan or to remove one or more of the Component Programs. In the event no Claim Administrator is appointed, the Plan Administrator shall be the Claim Administrator.

(f) Claims. The responsibility to hear, review, and determine claims for Benefits.

(g) Communications. The responsibility to communicate the Plan, its Component Programs, and their eligibility requirements to the Employees and to notify Employees when they become eligible to participate.

(h) Determination of Contributions and Premiums. The responsibility for determining that any contributions and premiums comply with the requirements of the Plan as to amount and time of payment.

(i) Determinations. The discretionary power and authority to decide all questions of eligibility for participation in the Plan and for the payment of Benefits and to determine the amount and manner of the payment of Benefits.

(j) Elections. The responsibility to solicit and collect Election Forms and to communicate Participant Elections to the Employer so that the Employer may reduce Compensation in accordance with the Elections and credit the reduction amount for coverage under the designated Component Program(s).

(k) Errors and Omissions. The responsibility to correct administrative and operational errors and omissions.

(l) Information. The responsibility to obtain, to the extent reasonably possible, all information necessary for the proper administration of the Plan.

(m) Operation of Plan. All other powers and duties with respect to the operation and management of the Plan conferred upon the Administrator by this Plan or necessary and appropriate thereto, except those powers and duties allocated to another named fiduciary in this Plan.

(n) Participant Records. The responsibility to make available to any Participant, upon request, such records as pertain exclusively to the examining Participant (for examination during business hours).

(o) Payment of Administrative Expenses. The responsibility to pay its portion of all reasonable and necessary expenses, fees, and charges (including fees for attorneys, actuaries, accountants, agents, or other persons) incurred in connection with the administration or operation of the Plan, unless it directs that the expenses be paid from the general assets of the Employer.

(p) Plan Interpretation. The discretionary power and authority to interpret all terms and provisions of the Plan, including the power to correct any defect, supply any omission, or reconcile any inconsistency.

(q) Procedures. The responsibility to establish or approve the manner of making an Election, designation, application, or claim permitted hereunder.

(r) Report. The responsibility to report to other plan fiduciaries or the Claim Administrator as necessary or appropriate with respect to the administration, operation, and management of the Plan.

10.2 Allocation and Delegation of Administrative Responsibilities

The Plan Administrator may delegate responsibility for the administration, operation, or management of the Plan to a person or may allocate such responsibility among two or more persons including, but not limited to, an administrative committee or a Claim Administrator. If an administrative committee is appointed, the Plan Administrator shall select its members and establish the procedures under which it shall operate. The appointed administrative committee shall have the powers and duties of the Plan Administrator, which are described in this article, except as otherwise provided by the Plan Administrator.

10.3 Indemnification

The Plan Administrator shall indemnify and hold harmless each of its Employees to whom it has delegated responsibility for the operation and administration of this Plan against any and all claims, loss, damages, expense, and liability arising from any action or failure to act, except when the same is judicially determined to be due to gross negligence or willful misconduct of such person. The Plan Administrator may choose, at its own expense and discretion, to purchase

and keep in effect liability insurance for each such person to cover a part or all of any such claims, loss, damage, expense, and liability.

10.4 Claim Administrator's Powers and Duties

The Claim Administrator shall have such powers as set forth in the administration agreement entered into between the Employer and the Claim Administrator.

10.5 Information to be Furnished to Plan Administrator

Participants shall furnish to the Plan Administrator such evidence, data, or information as it may request.

10.6 Records

The regularly kept records of the Plan Administrator and the Employer shall be conclusive evidence of the status of a Participant and all other matters contained therein applicable to this Plan.

10.7 Fiduciary Capacity

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Each fiduciary under the Plan shall carry out its duties with the care, prudence, and diligence that a prudent person acting in a like capacity and familiarity with such matters would use in the conduct of an enterprise of like character with like aims under circumstances then prevailing. Moreover, any Plan fiduciary shall have full discretionary authority in the exercise of its powers and duties. A fiduciary shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this section.

10.8 Fiduciary Interrelationship

Each Plan fiduciary warrants that any of its actions are in accordance with the Plan. Each Plan fiduciary may rely upon the action of another Plan fiduciary and is not required to investigate the propriety of any actions. Each Plan fiduciary shall be responsible for the proper exercise of its responsibilities. Each Plan fiduciary may rely upon tables, valuations, certificates, opinions, and reports furnished by another Plan fiduciary or by accountants, counsel, or other consultants engaged by the Plan Administrator. A fiduciary shall not be liable for any act or omission by another relating to the Plan.

10.9 Administrative Decisions Final

The decision of the Plan Administrator in matters within its jurisdiction shall be final, binding, and conclusive upon the Employer and upon each Employee, Dependent, Participant, former Participant, and every other person or party interested or concerned.

ARTICLE XI: AMENDMENT AND TERMINATION OF PLAN

11.1 Amendment

The Plan Sponsor may amend, modify, change, or revise the Plan or any Component Program at any time, provided that no amendment shall retroactively deprive any Participant of any Benefit for a claim incurred before the date of the amendment, modification, change, or revision, unless necessary to comply with applicable laws or regulations. The terms of the Plan may not be modified by any oral statements made by the Plan Sponsor or any of its directors, officers, Employees, agents or authorized representatives, including, but not limited to, the Claim Administrator.

11.2 Termination

The following provisions shall apply to termination of the Plan:

(a) By Plan Sponsor. The Plan Sponsor may discontinue or terminate this Plan at any time.

(b) Mandatory. The Plan shall terminate upon liquidation or discontinuance of the business of the Plan Sponsor, adjudication of the Plan Sponsor as bankrupt, or a general assignment by the Plan Sponsor to or for the benefit of its creditors.

(c) Change of Form. Unless continued, the Plan also shall terminate upon the merger or consolidation of the Plan Sponsor into another entity that is the survivor, the consolidation, or other reorganization of the Plan Sponsor, or the sale of substantially all of the Plan Sponsor's assets.

11.3 Termination Distribution

Upon termination or partial termination of the Plan, remaining assets, if any, shall be applied or distributed under one of the following methods, after a reasonable period of final claims administration and after all expenses of administration have been paid or accrued:

(a) Benefits. Be transferred to another cafeteria plan or arrangement or be used to purchase, by insurance or other contract, benefits permitted under a cafeteria plan for Participants and former Participants at the date of termination.

(b) Forfeitures. Be distributed in any manner permitted by applicable law for the allocation of forfeitures.

In no event shall assets revert to or be applied for the benefit of the Plan Sponsor other than as provided in subsection (a) or (b) above. The application or distribution of assets under subsection (a) or (b) above shall not discriminate in favor of Highly Compensated Participants.

11.4 Merger or Consolidation of Plan

A merger or consolidation of the Plan shall not occur unless both of the following conditions are met:

(a) Qualification. The other plan is a cafeteria plan under Code Section 125.

(b) Equal Benefit. Each Participant's reimbursement Account(s) will be at least equal to the Participant's reimbursement Account(s) if the Plan were terminated immediately before the merger or consolidation.

ARTICLE XII: MISCELLANEOUS PROVISIONS

12.1 Non-Alienation of Benefits

Amounts payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, execution, or levy of any kind, either voluntary or involuntary, including any liability that is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of a Participant, before actually being received by the person entitled to the Benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, execute levy upon, or otherwise dispose of any right to Benefits payable hereunder shall be void.

12.2 Effect upon Other Compensation-Related Plans

Participation in this Plan is not intended to affect any other Compensation-related employee benefit plans that are maintained or sponsored by the Employer. Any contributions or benefits under such other plans with respect to a Participant shall, to the extent permitted by law and not otherwise provided for in such other plan, include any amounts by which the Participant's Compensation may be reduced pursuant to the provisions of this Plan.

12.3 Effect upon Employment Relationship

No Participant shall have a right or claim under the Plan except in accordance with its provisions. The Plan shall not create a contract of employment between the Employer and a Participant or otherwise confer upon a Participant or other person a legal right to continuation of employment, nor shall it limit or qualify the right of the Employer to discharge or retire a Participant.

12.4 Source of Benefits

All Benefits shall be paid or provided for solely as provided in the Component Programs. Nothing herein shall be construed to require the maintenance of a separate trust for the benefit of any Participant.

12.5 Limitation on Liability

The Employer does not guarantee benefits under any insurance policy, HMO, or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under such policy or contract.

12.6 Benefits Provided through Third Parties

In the case of any benefit provided through a third party, such as an insurance company, HMO, or other benefit provider, pursuant to a contract or policy with such third party, if there is any conflict or inconsistency between the description of benefits contained in this Plan or the Component Program and such contract or policy, the terms of such contract or policy shall control.

12.7 No Participant Interest in Employer

Nothing in the Plan shall be construed to give an Employee, Participant, or beneficiary an interest in the assets or business affairs of the Employer or the right to examine the books and records of the Employer.

12.8 Gender and Number

Except when the context indicates to the contrary, when used herein, masculine terms shall be deemed to include the feminine and neuter, and terms in the singular shall be deemed to include the plural and the plural the singular.

12.9 Headings

The headings of articles and sections are included solely for convenience of reference, and if there is any conflict between the headings and the text of this Plan, the text shall control.

12.10 Construction

Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

12.11 Binding Effect

This Plan shall be binding upon the Employer, Participants, Spouses, Dependents, and beneficiaries and their respective successors and assigns.

12.12 Entire Agreement

The Plan constitutes the entire agreement. All previous negotiations, representations, or agreements are merged and are void unless expressly incorporated into the Plan.