

THORNAPPLE KELLOGG SCHOOLS

FLEXIBLE BENEFITS PLAN

(Restated effective as of September 1, 2010)

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THORNAPPLE KELLOGG SCHOOLS

FLEXIBLE BENEFITS PLAN

Article 1

Introduction

1.1 History of the Plan

Thornapple Kellogg Schools established the Thornapple Kellogg Schools Flexible Benefits Plan for the purpose of providing eligible Employees with a choice between cash and certain tax-free benefits.

1.2 This Document

By this document, Plan Sponsor is amending and restating the Plan effective as of September 1, 2010. The amended and restated Plan is intended to qualify as a cafeteria plan under Section 125 of the Code and is to be interpreted in a manner consistent with the requirements of Section 125.

Article 2

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 Board of Education

“Board of Education” means the governing body of Plan Sponsor.

2.2 COBRA

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.3 Code

“Code” means the Internal Revenue Code of 1986, as amended.

2.4 Compensation

“Compensation” means salary, hourly wages, overtime pay and amounts described in Section 4.6(c)(1) which are paid to a Participant by Employer during a Plan Year in connection with personal services provided by the Participant.

2.5 Compensation Reductions

“Compensation Reductions” means the amount by which a Participant reduces his Compensation to purchase benefits under the Plan (i.e., pre-tax contributions to the Plan). Compensation Reductions shall be periodically deducted from a Participant’s paychecks during payroll periods during the Plan Year. However, if a Participant is paid over a less than 12-month period (such as a nine-month period) during a Plan Year, the Participant’s Compensation Reductions shall occur over that shorter period instead of the entire Plan Year.

2.6 Covered Employment

“Covered Employment” means employment in a job classification that is eligible to participate in the Plan under Section 3.1.

2.7 Dependent Care Spending Account

“Dependent Care Spending Account” means the Flexible Spending Account established and maintained by Plan Sponsor under Section 6.1 to record the allocation of a Participant’s Compensation Reductions for the reimbursement of dependent care expenses.

2.8 Dependent Care Spending Plan

“Dependent Care Spending Plan” means the Thornapple Kellogg Schools Dependent Care Spending Plan described in Article 6. The Dependent Care Spending Plan shall be considered a “separate” plan to the extent required by the Code and the U.S. Department of Treasury regulations.

2.9 Election Form

“Election Form” means the agreement entered into between Employer and a Participant, as provided in Section 4.3. The election process may be carried out in writing or electronically (such as through an online computer system or telephone system). All references to an Election Form in the Plan shall be interpreted accordingly. Employees shall be notified of the election procedures.

2.10 Eligible Individual

“Eligible Individual” means an individual described in Section 223(c)(1) of the Code who is:

- (a) Covered under a High Deductible Health Plan; and
- (b) Not covered under any health plan:
 - (1) Which is not a High Deductible Health Plan; and
 - (2) Which provides coverage for any benefit which is covered under the High Deductible Health Plan.

2.11 Employee

“Employee” means any person who, for tax purposes, is considered by Employer to be a common-law employee of Employer. A person who is treated by Employer as an independent contractor or a leased employee for tax purposes is not an Employee.

2.12 Employer

“Employer” means Plan Sponsor.

2.13 Flexible Spending Accounts

“Flexible Spending Accounts” means the bookkeeping accounts established and maintained to record the amount of medical reimbursement benefits and dependent care reimbursement benefits available to a Participant under Article 5 and Article 6 of the Plan.

2.14 FMLA

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

2.15 Health Savings Account

“Health Savings Account” means a health savings account as defined in Section 223 of the Code.

2.16 High Deductible Health Plan

“High Deductible Health Plan” means a high deductible health plan as defined in Section 223 of the Code.

2.17 Highly Compensated Employee

“Highly Compensated Employee” means a highly compensated employee under Section 414(q) of the Code.

2.18 Highly Compensated Participant

“Highly Compensated Participant” means a Participant who is:

- (a) An officer of Employer;
- (b) A Highly Compensated Employee; or
- (c) A spouse or dependent of an individual described in subsections (a) or (b) of this Section.

2.19 HIPAA

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.20 Medical Spending Account

“Medical Spending Account” means the Flexible Spending Account established and maintained by Plan Sponsor under Section 5.1 to record the allocation of a Participant’s Compensation Reductions for the reimbursement of qualifying medical expenses.

2.21 Medical Spending Plan

“Medical Spending Plan” means the Thornapple Kellogg Schools Medical Spending Plan described in Article 5. The Medical Spending Plan shall be considered a “separate” plan to the extent required by the Code and the U.S. Department of Treasury regulations.

2.22 Open Enrollment Period

“Open Enrollment Period” means, with respect to each Plan Year, the time period established by Employer for a Participant to make his elections for that Plan Year. The Open Enrollment Period shall be determined by Employer and communicated to Participants before the beginning of each Plan Year. The elections made during the Open Enrollment Period shall become effective the first day of the following Plan Year.

2.23 Participant

“Participant” means a current or former Employee who has satisfied the participation requirements under Article 3 and who is enrolled in the Plan or who is specifically authorized to participate in the Plan.

2.24 Plan

“Plan” means the Thornapple Kellogg Schools Flexible Benefits Plan.

2.25 Plan Administrator

“Plan Administrator” means the named fiduciary responsible for the operation and administration of the Plan. Plan Sponsor shall be the Plan Administrator.

2.26 Plan Sponsor

“Plan Sponsor” means Thornapple Kellogg Schools.

2.27 Plan Year

For union Employees, “Plan Year” means the 12-consecutive-month period beginning on September 1 and ending on the following August 31. However, for administrators and non-union Employees, “Plan Year” means the 12-consecutive-month period beginning on July 1 and ending on the following June 30.

2.28 Qualified Benefits

“Qualified Benefits” means benefits as described in Section 4.2(d) which are generally not includable in a Participant’s gross income and which may be purchased under a cafeteria plan pursuant to Section 125(f) of the Code.

2.29 Welfare Benefits Plan

“Welfare Benefits Plan” means any group benefits plan or plans providing welfare benefits (including group health benefits) that Employer periodically makes available to Employees and their dependents.

Article 3

Participation

3.1 Eligibility and Participation

An Employee who is eligible under this Section shall be considered to work in Covered Employment and shall become a Participant on the dates specified below:

(a) **Welfare Benefits Plan and Other Qualified Benefits** Each Employee who is eligible to participate in the Welfare Benefits Plan and other Qualified Benefits as described in Section 4.2(d) shall be eligible to participate in this Plan for purposes of electing coverage and paying any required cost on a pre-tax basis with Compensation Reductions or waiving coverage. Participation in this Plan for this purpose shall begin on the date the Employee becomes a participant in the Welfare Benefits Plan or for other Qualified Benefits, as applicable.

(b) **Flexible Spending Accounts** An Employee’s eligibility to participate in the Flexible Spending Accounts shall be determined as follows:

(1) Each Employee who is eligible for group health benefits under the Welfare Benefits Plan shall be eligible to participate in this Plan for purposes of electing to have Compensation Reductions credited to his Medical Spending Account.

(2) Each Employee of Employer shall be eligible to participate in this Plan for purposes of electing to have Compensation Reductions credited to his Dependent Care Spending Account.

Participation in the Flexible Spending Accounts shall begin on the date the individual becomes an eligible Employee (i.e., date of hire), provided the Employee delivers a completed Election Form to Employer no later than 30 days after the date of initial eligibility. If a completed Election Form is not timely delivered to Employer, the Employee may not participate in the Flexible Spending Accounts portion of the Plan until the next Plan Year (see Section 4.3(b)) except as otherwise provided in Section 4.4.

3.2 Termination of Participation

(a) When Termination Occurs An individual's participation in the Plan shall terminate on the earliest of the following dates:

(1) The date on which the individual revokes an election to participate in the Plan during the Plan Year pursuant to Section 4.4, Section 4.5 or Section 4.6. This revocation of participation may apply to the individual's entire participation in the Plan or only a portion of the individual's participation in the Plan (e.g., the Medical Spending Account portion).

(2) The date on which the individual terminates employment with Employer or otherwise ceases to work in Covered Employment, except when continued participation is expressly provided by the Plan.

(3) The date as of which Employer terminates the individual's participation in the Plan for cause which includes a termination for fraud and misrepresentation in an application for enrollment or a claim for benefits.

(4) The first day of the first Plan Year in which the individual elects not to participate. This termination of participation rule may apply to the individual's entire participation in the Plan or only a portion of the individual's participation in the Plan (e.g., the Medical Spending Account portion).

(5) The date the Plan is terminated by Employer.

(b) Effect of Termination Upon termination of participation, the following rules shall then apply:

(1) The individual's continued participation and coverage under the Welfare Benefits Plan shall be determined under the terms and conditions of that plan.

(2) The individual shall be ineligible to receive any additional Compensation attributable to an election to waive health coverage under the Welfare Benefits Plan. If the individual receives excess Compensation, the individual shall repay the excess amount to Employer.

(3) Except as otherwise expressly provided by the Plan, the individual shall be ineligible to use any additional Compensation attributable to an election to waive health coverage under the Welfare Benefits Plan toward the purchase of any Qualified Benefits.

(4) The individual shall be ineligible to have additional amounts credited to his Flexible Spending Accounts. Any amount remaining in the individual's Medical Spending 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 under the Medical Spending Account for claims for

eligible expenses incurred after the date his participation terminated, except to the extent the individual continues to participate in his Medical Spending Account as described in Section 3.3. Any amount remaining in the individual's Dependent Care Spending Account may be applied toward the reimbursement of claims for eligible expenses incurred through the end of the Plan Year in which the individual's participation terminated.

3.3 Continuation Coverage

An individual whose participation in the Plan terminates under Section 3.2 has the option of continuing to participate in his Medical Spending Account to the extent required by the continuation coverage provisions of COBRA. Under COBRA, if the amount contributed to the individual's Medical Spending Account for the Plan Year exceeds the claims the Participant has submitted for the Plan Year, the Participant shall generally be eligible to continue to participate for the remaining portion of the Plan Year during which the individual's participation terminated. Continuation coverage is generally not available for a subsequent Plan Year unless, pursuant to U.S. Department of Treasury regulations, certain requirements are not met (e.g., benefits under the individual's Medical Spending Account are not excepted benefits under HIPAA – see Section 5.8).

If an individual is eligible to elect COBRA with respect to his Medical Spending Account, 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 making contributions on a monthly basis in an amount equal to 102% of the Compensation Reductions which were allocated to the individual's Medical Spending Account each month before the date participation terminated. Contributions shall generally be after-tax, but may be by Compensation Reductions to the extent the Participant receives additional Compensation from Employer (for example, the last paycheck paid to a terminated Participant or any ongoing paychecks to a Participant who transfers to an ineligible job classification). Contributions for a month must be paid by the first day of that month. However, there is a 30-day grace period for timely payment. Participation shall be terminated if contributions are not made on a timely basis.

If an individual does not elect to continue to participate in his Medical Spending Account under this Section or his participation is terminated for failing to timely make after-tax contributions, any amounts remaining in the individual's Medical Spending Account after paying claims incurred while a Participant shall be forfeited.

If an individual participating in the Medical Spending Account goes on a military leave of absence, Employer shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements shall only apply to the extent they provide the Employee with more favorable coverage than under COBRA (i.e., coverage for a longer period of time or less costly coverage).

3.4 Participation After Reemployment

Notwithstanding any other provision of the Plan, a special participation rule applies if the Participant:

- (a) Elects benefits under the Plan as provided in Article 4;
- (b) Separates from service with Employer; and
- (c) Is rehired and again becomes eligible for coverage within 30 days of separation from service and during the same Plan Year.

In that event, the Participant may reinstate his prior election with respect to accident and health coverage and any group term life insurance coverage and make payment by Compensation Reductions. The Participant may not use Compensation Reductions to pay his cost of accident and health coverage and any group term life insurance coverage which is not identical to his prior election until the first day of the first Plan Year following the Plan Year in which he terminated employment with Employer. However, the Participant may make payment for such latter coverage by after-tax contributions.

If such a Participant is rehired and again becomes eligible for coverage more than 30 days after separation from service, the Participant shall be treated as a newly-hired Employee.

Article 4

Benefits

4.1 This Article Generally

This Article describes the benefit choices which are available to a Participant under the Plan and the procedures for the Participant to make his elections. A Participant may make new choices for each Plan Year.

4.2 Benefit Choices

A Participant may choose to receive one or more of the following benefits:

(a) Welfare Benefits Plan

(1) **Elect Coverage** A Participant may elect coverage under the Welfare Benefits Plan for himself and his eligible dependents for whom coverage can be purchased on a before-tax basis under the Code, subject to the following:

(A) The Participant may be required to pay all or part of the cost of coverage under the Welfare Benefits Plan. The Participant shall pay such cost with his Compensation Reductions. Employer shall inform the Participant of the applicable Compensation Reductions required to pay a Participant's cost of coverage. The cost of coverage depends on various factors, such as whether coverage is elected for the Participant only or for the Participant and one or more of his dependents.

(B) The actual payment of benefits under the Welfare Benefits Plan is subject to the terms and conditions of that plan. Any

welfare benefit under this Section which is provided through a policy of an insurance company shall not be effective until the insurance company begins to provide coverage for the Participant and, if applicable, his dependents. Employer is not the guarantor of the availability of such insurance coverage or of the payment of any benefits to be provided by an insurance company. With respect to any fully-insured benefits, Employer's sole obligation is to remit the premiums to the insurance company.

(2) **Waive Coverage** A Participant may elect to waive all health coverage under the Welfare Benefits Plan for himself and his dependents.

A Participant who waives all health coverage in the Welfare Benefits Plan for himself and his dependents may have his Compensation increased by an amount determined by Employer for each Plan Year. The amount of any additional Compensation may vary depending on the Participant's job classification and the type of coverage waived by the Participant. Employer shall inform Participants of the time table for paying the additional Compensation (e.g., in equal installments over each pay period or quarter of the Plan Year, in a lump sum at Plan Year end, etc.). The additional Compensation shall be subject to all required tax withholdings. The Participant may use/receive the additional Compensation as follows:

(A) The Participant may choose to apply all or part of the additional Compensation toward the purchase of Qualified Benefits, including any Flexible Spending Accounts available under the Plan; and/or

(B) The Participant may choose to receive all or part of the additional Compensation through Employer's payroll system during the Plan Year to which the election relates.

However, as provided in Section 3.2, a Participant shall not receive any additional Compensation on account of this election for any time period after he is not eligible to participate in the Plan (e.g., terminates employment with Employer).

(3) **Participation After Waiver** If participation under the Welfare Benefits Plan is waived for any person, and that person desires to be covered by the Welfare Benefits Plan at a later date, any applicable pre-existing condition provisions in the Welfare Benefits Plan may apply. However, notwithstanding the rules set forth in this paragraph, no pre-existing condition limitation or exclusion may apply to a Participant for whom coverage is reinstated following an FMLA leave (see Section 4.6).

(b) **Medical Spending Account** A Participant may elect to have Compensation Reductions and/or the additional Compensation received upon the waiver

of health coverage under the Welfare Benefits Plan credited to his Medical Spending Account.

(c) **Dependent Care Spending Account** A Participant may elect to have Compensation Reductions and/or the additional Compensation received upon the waiver of health coverage under the Welfare Benefits Plan credited to his Dependent Care Spending Account.

(d) **Other Qualified Benefits** Employer may periodically make one or more supplemental health, life or disability coverages available to Participants and their dependents; provided, however, that each supplemental coverage shall be a “qualified benefit” under Section 125 of the Code. The cost of any supplemental coverage shall be paid by the Participant’s Compensation Reductions, the additional Compensation received upon the waiver of health coverage under the Welfare Benefits Plan and/or the Participant’s after-tax payments. If purchased with after-tax payments, the restrictions described in Sections 4.4 and 4.5 shall not apply.

4.3 **Election of Benefits**

(a) **Initial Election** Each Employee shall complete and return an Election Form to Employer before the date he becomes a Participant. However, where participation for a benefit begins on the date the individual becomes an eligible Employee (i.e., date of hire), the Employee may deliver a completed Election Form to Employer no later than 30 days after the date of initial eligibility. If an Employee does not deliver a completed Election Form to Employer before the required date, the Employee shall be ineligible to purchase coverage under the Welfare Benefits Plan or purchase Qualified Benefits on a before-tax basis and no Compensation Reductions shall be credited to his Flexible Spending Accounts. (See Section 3.1(b) regarding the timely delivery of an Election Form regarding the Flexible Spending Accounts.) Further, the Employee shall not receive additional Compensation for waiving health coverage in the Welfare Benefits Plan.

(b) **Subsequent Election** Each Participant may complete a new Election Form for each subsequent Plan Year and deliver it to Employer during the Open Enrollment Period. The Election Form shall become effective on the first day of the next Plan Year and shall remain in effect through the last day of the next Plan Year unless changed as provided in Section 4.4.

If a Participant does not complete a new Election Form and deliver it to Employer during the Open Enrollment Period, the following rules shall apply:

(1) The Participant’s current election regarding coverage under the Welfare Benefits Plan and other Qualified Benefits shall continue for all subsequent Plan Years, unless changed as provided in Section 4.4. If the Participant is required to pay all or part of the cost of coverage in the Welfare Benefits Plan and for other Qualified Benefits, he shall be considered to have agreed to Compensation Reductions for the subsequent Plan Year equal to the Participant’s share of the cost of coverage for that Plan Year. If the Participant’s

current election under the Welfare Benefits Plan is not being offered by Employer during a subsequent Plan Year, the Participant shall be enrolled in the most similar option.

(2) The Participant shall not be eligible to reduce his Compensation for participation in the Flexible Spending Accounts for the subsequent Plan Year.

4.4 Changes in Benefit Election During the Plan Year

A Participant's election of benefits, including the amount of any Compensation Reductions, shall not be changed during a Plan Year, except as follows:

(a) A Participant's election of benefits may be changed due to a "change in status," in accordance with Section 4.5.

(b) A Participant's election may be changed if the Participant goes on an FMLA leave or non-FMLA leave and changes his election in accordance with Sections 4.6 and 4.7.

(c) A Participant's election may be changed to satisfy any nondiscrimination rule in the Code, as described in Section 4.8.

(d) A Participant's Compensation Reductions may be automatically changed, on a prospective and reasonable and consistent basis, to reflect any increase or decrease in the cost of coverage under the Welfare Benefits Plan in which the Participant or the 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:

(1) If the cost decrease for an option is significant, the Participant may elect a corresponding decrease in the amount of the Participant's 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.

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

(A) Elect a corresponding increase in the amount of the Participant's Compensation Reductions;

(B) Revoke the Participant's current election and elect other similar coverage on a prospective basis; or

(C) Subject to 4.2(a)(2), 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 Employer (such as changing the amount of Compensation Reductions for a class of Employees). This subsection does not apply to a Participant's Medical Spending Account.

(e) A Participant's Compensation Reductions may be changed with respect to the Participant's Dependent Care Spending 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 Section 152(a)(1) through (8) of the Code, incorporating the rules of Section 152(b)(1) and (2) of the Code.

(f) A Participant's election may be changed if coverage under any Welfare Benefits Plan 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 Welfare Benefits Plan which 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 Spending Account.

(g) A Participant's election may be changed if Employer offers a new or significantly improved benefit or coverage option. If Employer offers a new or significantly improved option, the Participant may prospectively elect the new or significantly improved option. This subsection does not apply to a Participant's Medical Spending Account.

(h) A Participant's election may be prospectively changed if it is on account of and corresponds with a change under another group health plan (either of Employer or another employer) ("Other Plan") where:

(1) The Other Plan permits an election change that would be permitted under this Section; or

(2) 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 Spending Account.

(i) A Participant's election regarding health coverage may be changed in order to exercise special enrollment rights under HIPAA, even if the change in election would not be permitted under Section 4.5. Further, if the special enrollment rights situation is the addition of a new 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.

(j) A Participant's election with respect to accident or health coverage may be changed because of a judgment, decree or order ("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:

(1) Elect coverage for the child if the Order requires accident or health coverage under the Employer plan(s) in which the Participant is enrolled; or

(2) Cancel coverage for the child if the 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 Employer-provided accident or health coverage 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 Employer-provided accident or health coverage 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 Spending Account.

In no event may a Participant's election of benefits for a Plan Year be changed after the Plan Year ends.

4.5 Change in Status

A Participant may change his election of benefits during a Plan Year due to 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:

(1) **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.

(2) **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.

(3) **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 which affects an individual's eligibility for benefits.

(4) **Ineligible Dependent** An event that causes a Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, student status, or any similar circumstance.

(5) **Residence** A change in the place of residence of the Participant or the Participant's spouse or dependent.

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

(1) With respect to Employer-provided accident or health coverage and group term life insurance 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 accident or health coverage because the Participant becomes eligible for coverage under the plan of the employer of the Participant's spouse or dependent due to a legal marital or employment change in status, the change shall only be permitted if coverage is or shall be actually obtained under the Other Plan, as defined in Section 4.4(h).

(2) With respect to Employer-provided group term life insurance coverage or disability income coverage, an election to increase or decrease coverage shall be considered to be on account of, and correspond with, a change in status that affects eligibility for coverage.

(3) With respect to the Medical Spending Account, an election by the Participant to decrease the annual contribution amount below the amount which has already been reimbursed to the Participant for the Plan Year shall automatically not be considered to satisfy the consistency requirement described in this subsection (b).

(4) With respect to the Dependent Care Spending 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 which 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, any new election involving an independent, third-party provider shall only be approved to the extent permitted by the independent, third-party provider.

4.6 **Special Rules for Participants Taking FMLA Leave**

Notwithstanding any other provision of the Plan, the following special rules apply to a Participant who 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 health coverage under the Welfare Benefits Plan, the Participant may revoke that election upon taking the FMLA leave for the remainder of the Plan Year.

(c) If the Participant does not revoke an election to receive health coverage under the Welfare Benefits Plan upon the taking of an FMLA leave, the election to receive health coverage shall continue and the Participant shall continue to be responsible to pay the required cost of health coverage during the FMLA leave. The Participant's required cost of health coverage shall be payable as follows:

(1) **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 health coverage in the same manner as immediately before the taking of 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 during which the Participant is receiving continued salary or hourly wages, payment for unused vacation or sick time, or any self-insured short-term disability income benefits from Employer.

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

(A) **Pre-Pay** The Participant may prepay the required cost of health coverage prior to the commencement of the FMLA leave. Prepayment may be made on a before-tax Compensation Reduction basis under the Plan to the extent the Participant shall receive Compensation prior to the taking of the FMLA leave. However, prepayment on a before-tax Compensation Reduction basis may 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 pre-pay on an after-tax basis.

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

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

(d) If the Participant fails to timely pay the required cost of health coverage in accordance with U.S. Department of Labor Regulations issued pursuant to FMLA and Employer's FMLA policy, the Participant's health coverage under the Welfare Benefits Plan may be terminated in accordance with U.S. Department of Labor regulations issued pursuant to FMLA and Employer's FMLA policy. If Employer chooses to continue health coverage for a Participant who fails to make the required payments while on an FMLA leave, 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 Employer's FMLA policy.

(e) Upon return from the FMLA leave, a Participant may elect to be reinstated for health coverage under the Welfare Benefits Plan if health coverage terminated while on the FMLA leave either by revocation or nonpayment of required cost. However, reinstatement shall be automatic if Employer requires automatic reinstatement for Employees who return from non-FMLA unpaid leaves of absence. Upon reinstatement, the Participant's health coverage shall be on the same basis as immediately prior to the taking of the FMLA leave. Thus, for example, the reinstatement must be made immediately, with no waiting period or pre-existing condition limitation or exclusion.

(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 a new or significantly improved benefit or coverage option is offered during a Plan Year.

(g) If Employer pays additional Compensation to a Participant for waiving health coverage and the Participant takes an unpaid FMLA leave, the Participant shall not receive any additional Compensation for the time period when he is on the unpaid leave.

(h) For purposes of this Section, any reference to Employer's Welfare Benefits Plan shall also include the Participant's Medical Spending Account. The rules contained in this Section shall separately apply to the Medical Spending Account. In addition, if the Participant's coverage under the Medical Spending Account 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 Participant's Medical Spending Account, the Participant's coverage for the remainder of the Plan Year shall either be equal to the Participant's election for the Plan Year, reduced by prior reimbursements, or 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.

4.7 Special Rules for Participants Taking Non-FMLA Leaves

The rules contained in Section 4.6 shall also apply to a Participant who goes on a non-FMLA approved leave of absence.

4.8 Nondiscrimination Rules

For each Plan Year, the following nondiscrimination rules shall be satisfied:

(a) The Plan shall be made available to a nondiscriminatory classification of Employees, as described in Section 410(b)(2)(A)(i) of the Code; and

(b) The Plan shall not discriminate in favor of Highly Compensated Participants with regard to contributions or benefits, except as permitted under Section 125 of the Code.

If the Plan Administrator determines at any time that the Plan may not satisfy the nondiscrimination rules in the Code, the Plan Administrator may take whatever action it considers appropriate to assure compliance with the rules. Any action shall be taken uniformly with respect to similarly situated Participants. The action may include the modification of Participants' elections, with or without the consent of the Participants.

The Plan may be disaggregated into sub-plans for purposes of the nondiscrimination rules described in subsections (a) and (b).

4.9 Maximum Compensation Reductions and Maximum Employer Contributions

Subject to Section 4.8, a Participant's maximum Compensation Reductions in a Plan Year shall be the sum of the following:

(a) The Participant's Compensation Reductions to pay required contributions for the most expensive coverages under the Welfare Benefits Plan.

(b) The maximum Compensation Reductions permitted to purchase Qualified Benefits.

(c) The maximum Compensation Reductions permitted to a Participant's Medical Spending Account under Section 5.2.

(d) The maximum Compensation Reductions permitted to a Participant's Dependent Care Spending Account under Section 6.2.

Subject to Section 4.8, a Participant's maximum Employer contribution for a Plan Year shall be the maximum cost of benefits provided by Employer under the Plan.

Article 5

Medical Spending Plan

5.1 This Article Generally

Plan Sponsor shall establish and maintain the Thornapple Kellogg Schools Medical Spending Plan for the purpose of providing eligible Employees with the opportunity to receive reimbursement of Qualifying Medical Expenses in a manner which is excludable from gross income under Section 105(b) of the Code. The Medical Spending Plan is intended to qualify as a medical reimbursement plan under Section 105(h) of the Code and is to be interpreted in a manner consistent with the requirements of Section 105(h) of the Code. The Medical Spending Plan is set forth in this Article.

Employer shall establish and maintain a Medical Spending Account for each Participant who elects to receive reimbursement for Qualifying Medical Expenses under the Medical Spending Plan. The Medical Spending Account shall be for bookkeeping purposes only.

5.2 Crediting of Medical Spending Account

A Participant may allocate a portion of his Compensation Reductions for the reimbursement of Qualifying Medical Expenses under the Plan. In addition, if a Participant waives health coverage under the Welfare Benefits Plan under Section 4.2, he may allocate all or a portion of his additional Compensation for the reimbursement of Qualifying Medical Expenses under the Plan. The allocation shall be made by the Participant in his Election Form. The amount allocated for each Participant under this Section shall be credited to the Participant's Medical Spending Account.

The maximum amount which may be credited to a Participant's Medical Spending Account for each Plan Year shall be determined annually by Employer for non-union Employees and for union Employees, the maximum amount shall be specified in the applicable collective bargaining agreement or if not in the collective bargaining agreement, then as determined by Employer. The maximum amount shall be communicated to Participants during the Open Enrollment Period. However, the maximum amount may be prorated for an

individual's first year of participation if he became a Participant in the Plan after the first day of a Plan Year.

5.3 Covered Expenses

Amounts credited to a Participant's Medical Spending Account shall be used to reimburse the Participant for Qualifying Medical Expenses.

For purposes of this Article, "Qualifying Medical Expenses" means expenses for medical care, as defined in Section 213(d) of the Code, incurred by a Participant, spouse or dependent but only to the extent the expense is incurred during a Plan Year and is not reimbursed through insurance or any other source. For this purpose, a dependent shall be defined in accordance with Section 152 of the Code but determined without regard to Sections 152(b)(1), (b)(2) and (d)(1)(B) of the Code. However, notwithstanding any other provision of Section 152 of the Code, a dependent shall also include a Participant's child within the meaning of Section 152(f)(1) of the Code who has not attained age 27 as of the end of the calendar year, as provided by Section 105(b) of the Code, as amended by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. The following special rules apply in determining Qualifying Medical Expenses:

(a) Qualifying Medical Expenses shall include expenses incurred to satisfy prescription drug co-pays incurred by a Participant or the Participant's dependents under the Welfare Benefits Plan. However, for Participants who are enrolled in Employer's Medical Reimbursement Plan, prescription drug co-pays eligible for reimbursement under that plan shall be reimbursed under that plan before being eligible for reimbursement under this Plan.

(b) For administrators and non-union Employees, Qualifying Medical Expenses shall **also** include expenses incurred to satisfy deductibles incurred by a Participant or the Participant's dependents under the Welfare Benefits Plan. However, for Participants who are enrolled in Employer's Medical Reimbursement Plan, deductibles eligible for reimbursement under that plan shall be reimbursed under that plan before being eligible for reimbursement under this Plan.

(c) The cost of health coverage under any group plan or individual policy, including the Welfare Benefits Plan, shall not constitute a Qualifying Medical Expense for purposes of the Medical Spending Account.

(d) The cost of qualified long-term care insurance or services, as defined in Section 7702B of the Code, shall also not constitute a Qualifying Medical Expense for purposes of the Medical Spending Account.

(e) If the Participant is an Eligible Individual who contributes to a Health Savings Account established by Employer or Employer contributes to a Health Savings Account on behalf of the Participant as of the first day of the Plan Year as of which the Participant is covered by this Article, the term "Qualifying Medical Expenses" for each such Eligible Individual and all his eligible dependents for that Plan Year shall be defined in the same manner as described above, except that it shall be limited to

expenses incurred for dental or vision care, preventive care (as defined in IRS Notice 2004-23) and other expenses incurred after the minimum annual deductible under Employer's High Deductible Health Plan is satisfied. This is known as a combination limited purpose/post-deductible Medical Spending Account.

5.4 Reimbursement of Qualifying Medical Expenses

Benefits from a Participant's Medical Spending Account for each Plan Year shall be paid only for Qualifying Medical Expenses incurred during that Plan Year and during the time period in which the individual was a Participant. For purposes of this Section, a Qualifying Medical Expense shall be incurred on the date the service or supply is provided. 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. All claims for reimbursement must be filed no later than 90 days after the end of the Plan Year. Further, if a Participant terminates employment and participation in the Plan before the end of a Plan Year, the Participant's claims for reimbursement must be filed no later than 30 days after the date his participation in the Plan terminated.

Participants shall be entitled to uniform coverage under their Medical Spending Account throughout the Plan Year. A Participant shall be entitled to reimbursement for claims incurred at any time throughout the Plan Year, regardless of the balance in the Participant's Medical Spending Account. However, claims shall not be reimbursed to the extent they exceed the amounts a Participant has allocated under Section 5.2 to his Medical Spending Account for the Plan Year.

Claims shall be paid as soon as administratively feasible after the claim is received by the Plan Administrator, but in no event less frequently than monthly. At the end of a Plan Year, upon termination of an individual's participation, or upon termination of the Plan, all claims incurred as of the applicable date shall be paid to the extent of the balance in the Participant's Medical Spending Account.

5.5 Claims for Reimbursement

A Participant shall request reimbursement, in writing, on a form provided by the Plan Administrator. The form shall include the following information:

- (a) The amount, date and nature of the Qualifying Medical Expense for which reimbursement is requested;
- (b) The name and address of the person or entity to which the Qualifying Medical Expense was paid;
- (c) The name of the person for whom the Qualifying Medical Expense was incurred, and the person's relationship to the Participant;

(d) The amount recovered or expected to be recovered under any insurance arrangement or other source;

(e) A statement that the Qualifying Medical Expense has not been paid or reimbursed by, nor will the Participant seek payment or reimbursement under any other employer-sponsored plan, any federal, state, or other governmental plan or program, or any other source. If the Participant is enrolled in the combination limited purpose/post deductible Medical Spending Account, the claim for reimbursement must also provide information from an independent third party that the expenses were for a permitted limited purpose (i.e., dental, vision or preventative care) or were incurred after the deductible under Employer's High Deductible Health Plan had been satisfied; and

(f) Any other information required by the Plan Administrator.

Any bills, invoices or receipts documenting the Qualifying Medical Expenses shall accompany the form. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator shall verify each claim for reimbursement and determine whether the claim is for Qualifying Medical Expenses. All reimbursement checks shall be made payable to the Participant. The Plan shall not recognize an assignment of benefits.

5.6 Forfeiture of Medical Spending Account

If any balance remains in a Participant's Medical Spending 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.

5.7 Special Nondiscrimination Rule

In addition to the nondiscrimination rules described in Section 4.8, the Medical Spending Plan shall also be subject to the applicable nondiscrimination requirements under Section 105(h) of the Code. Section 105(h) of the Code prohibits discrimination in eligibility or benefits in favor of highly compensated individuals (as that term is defined in Section 105(h) of the Code).

5.8 HIPAA – Special Enrollment Rights and Certificate of Creditable Coverage Rules

For each Plan Year, a Participant's Medical Spending Account shall be considered an excepted benefit which is not subject to the special enrollment rights and certificate of creditable coverage rules of HIPAA if all three of the following requirements are satisfied:

(a) The maximum benefit payable by Employer under the Medical Spending Account for the Plan Year does not exceed two times the Participant's Compensation Reduction election under the Medical Spending Account for the Plan Year

(or, if greater, the amount of the Participant's Compensation Reduction election under the Medical Spending Account for the Plan Year plus \$500).

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

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

If a Participant's Medical Spending 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 Spending Account for the Plan Year (e.g., by granting special enrollment rights regarding the Medical Spending Account and by issuing any required certificates of creditable coverage upon termination of participation).

5.9 HIPAA Privacy and Security Rules

The Medical Spending Plan shall be subject to the following HIPAA Privacy and Security Rules:

(a) **Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")** Subject to obtaining written certification pursuant to subsection (c), the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

(1) Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.

(2) Modifying, amending or terminating the Plan.

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

(b) **Conditions of Disclosure** Plan Sponsor agrees that with respect to any PHI, it shall:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

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

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

(4) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for which it becomes aware.

(5) Make available to individual Participants who request access, the Participant's PHI in accordance with 45 CFR §164.524.

(6) Make available to individual Participants the right to request an amendment to the Participant's PHI and incorporate any amendments to the Participant's PHI in accordance with 45 CFR §164.526.

(7) Make available to Participants who request an accounting of disclosures of the Participant's PHI, the PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

(8) 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 for purposes of determining compliance by the Plan with the HIPAA privacy rules.

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

(10) Ensure that the adequate separation between Plan and Plan Sponsor, as required in 45 CFR §164.504(f)(2)(iii), is satisfied and that the terms set forth in subsection (e) are followed.

(11) Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment 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 and 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 Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth in subsection (b).

(d) **Permitted Uses and Disclosure of Summary Health Information** The Plan may disclose Summary Health Information to Plan Sponsor,

provided such Summary Health Information is only used by Plan Sponsor for the purpose of modifying, amending or terminating the Plan.

(e) **Adequate Separation Between Plan and Plan Sponsor**

(1) The Employees, or classes of Employees, who shall be given access to PHI shall be set forth in Plan Sponsor's HIPAA privacy policies and procedures for its group health plans.

(2) The access to and use of PHI by the individuals described in paragraph (1) above shall be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.

(3) In the event any of the individuals described in paragraph (1) do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

(4) To comply with the HIPAA security rules, 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 to Plan Sponsor**

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

(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) **Definitions** For purposes of this Section, the following terms shall have the following meanings:

(1) "Business Associate" means a person or entity who:

(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.); or

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

(3) “Protected Health Information” or “PHI” means information that is created or received by the Plan or a Business Associate of the Plan 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; and that identifies the Participant or for which 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 are considered to enable identification:

- (A)** Names;
- (B)** Street address, city, county, precinct, zip code;
- (C)** 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;
- (D)** Telephone numbers, fax numbers and electronic mail addresses;
- (E)** Social Security numbers;
- (F)** Medical record numbers;
- (G)** Health plan beneficiary numbers;
- (H)** Account numbers;
- (I)** Certificate/license numbers;
- (J)** Vehicle identifiers and serial numbers, including license plate numbers;
- (K)** Device identifiers and serial numbers;
- (L)** Web Universal Resource Locators (URLs);

- (M) Biometric identifiers, including finger and voice prints;
- (N) Full face photographic images and any comparable images; and
- (O) Any other unique identifying number, characteristic or code.

(4) “Summary Health Information” means information that may be individually identifiable health information that:

(A) Summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Plan Sponsor has provided health benefits under a health plan; and

(B) From which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

(i) **Hybrid Entity** This subsection applies to the extent the Plan provides any non-health benefits such as (but not limited to) Dependent Care Spending Account benefits which shall be considered “non-covered functions.” The Plan is a separate legal entity whose business activities include 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 only be a covered entity under the HIPAA privacy and security rules with respect to the health care component (the Medical Spending Accounts) of the Plan.

(j) **Participant Notification** Participants shall be notified of this Section in the notice of privacy practices.

Article 6

Dependent Care Spending Plan

6.1 This Article Generally

Plan Sponsor shall establish and maintain the Thornapple Kellogg Schools Dependent Care Spending Plan for the purpose of providing eligible Employees with the opportunity to receive reimbursement for Dependent Care Expenses in a manner which is excludable from gross income under Section 129 of the Code. The Dependent Care Spending Plan is intended to qualify as a dependent care assistance plan under Section 129 of the Code and is to be interpreted in a manner consistent with the requirements of Section 129 of the Code. The Dependent Care Spending Plan is set forth in this Article.

Employer shall establish and maintain a Dependent Care Spending Account for each Participant who elects to receive reimbursement for Dependent Care Expenses under the Dependent Care Spending Plan. The Dependent Care Spending Account shall be for bookkeeping purposes only.

6.2 Crediting of Dependent Care Spending Account

A Participant may allocate a portion of his Compensation Reductions for the reimbursement of Dependent Care Expenses under the Plan. In addition, if a Participant waives health coverage under the Welfare Benefits Plan under Section 4.2(a), he may allocate all or a portion of his additional Compensation for the reimbursement of Dependent Care Expenses under the Plan. The allocation shall be made by the Participant in his Election Form. The amount allocated shall be subject to the limitations described in this Section and shall be credited to the Participant's Dependent Care Spending Account.

The maximum amount which may be credited to a Participant's Dependent Care Spending Account during a calendar year shall be the lesser of the following amounts:

(a) \$5,000 (\$2,500 in the case of a married Participant filing a separate income tax return); or

(b) An amount equal to the Participant's Earned Income for the calendar year or, if the Participant is married on the last day of the calendar year, the lesser of the Earned Income of the Participant or his spouse. For purposes of this subsection, a spouse who is a Student or has a Total Disability during any month in which the Participant incurs Dependent Care Expenses shall be deemed to have the following Earned Income for the month:

(1) \$250, if there is one Qualifying Individual for whom the Participant incurs Dependent Care Expenses; or

(2) \$500, if there is more than one Qualifying Individual for whom the Participant incurs Dependent Care Expenses.

6.3 Covered Expenses

Amounts credited to a Participant's Dependent Care Spending Account shall be used to reimburse the Participant for Dependent Care Expenses.

6.4 Reimbursement of Dependent Care Expenses

Benefits from a Participant's Dependent Care Spending Account for each Plan Year shall be paid only for Dependent Care Expenses incurred during that Plan Year and during the time period in which the Employee was a Participant. For purposes of this Section, a Dependent Care Expense shall be incurred on the date the service is provided. All claims for reimbursement must be filed no later than 90 days after the end of the Plan Year.

Claims shall be paid only to the extent of the balance in the Participant's Dependent Care Spending Account at the time the claim is filed. If the balance in the Dependent

Care Spending Account is insufficient to pay a claim in full, the unpaid balance of the claim shall be carried over and paid when and if a sufficient amount is credited to the Dependent Care Spending Account later in the Plan Year.

Claims shall be paid as soon as administratively feasible after the claim is received by the Plan Administrator, but in no event less frequently than monthly. At the end of the Plan Year, upon termination of an individual's participation, or upon termination of the Plan, all claims incurred as of the applicable date shall be paid to the extent of the balance in the Participant's Dependent Care Spending Account.

6.5 No Reimbursement for Amounts Paid to Related Individuals

The Plan shall not reimburse a Participant for a Dependent Care Expense owed to the following individuals:

- (a) A Dependent of the Participant;
- (b) The spouse of the Participant; or
- (c) A child of the Participant if the child was under the age of 19 on the last day of the Participant's taxable year during which the Dependent Care Expense was incurred.

6.6 Claims for Reimbursement

A Participant shall request reimbursement, in writing, on a form provided by the Plan Administrator. The form shall include the following information:

- (a) The amount, date and nature of the Dependent Care Expense for which reimbursement is requested;
- (b) The name and address of the person or entity to which the Dependent Care Expense was paid;
- (c) The taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a person) of the entity or person that provided the dependent care, or certification that the Participant has obtained this information;
- (d) The name of the person for whom the Dependent Care Expense was incurred, and the person's relationship to the Participant;
- (e) The amount recovered or expected to be recovered under any other source; and
- (f) Any other information required by the Plan Administrator.

Any bills, invoices or receipts documenting the Dependent Care Expenses shall accompany the form. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator shall verify each claim for reimbursement and determine whether the claim is for Dependent Care Expenses. All reimbursement checks shall be made payable to the Participant. The Plan shall not pay benefits to the dependent care provider and shall not recognize an assignment of benefits.

6.7 Forfeiture of Dependent Care Spending Account

If any balance remains in a Participant's Dependent Care Spending 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 Dependent Care Expenses incurred during a subsequent Plan Year.

6.8 Statement of Expenses

On or before each January 31, Plan Sponsor shall provide each Participant with a written statement of the amounts reimbursed under the Plan for Dependent Care Expenses incurred during the preceding calendar year and/or the amounts allocated to the Participant's Dependent Care Spending Account for the preceding calendar year.

6.9 Special Nondiscrimination Rules

In addition to the nondiscrimination rules described in Section 4.8, the Dependent Care Spending Plan shall also be subject to the applicable nondiscrimination requirements under Section 129(d) of the Code which are described in this Section.

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

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

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

Any Employees with annual Compensation of less than \$25,000 may either be included or excluded for purposes of the 55% average benefits test. Further, any Employees excluded from participation who have not attained age 21 and completed one year of continuous employment may be excluded for purposes of the 55% average benefits test, to the extent permitted under Section 129(d)(9)(A) of the Code.

Plan Sponsor shall conduct periodic testing, including immediately following each Open Enrollment Period, to determine if the 55% average benefits test is being satisfied for each calendar year. If Plan Sponsor's testing indicates that the 55% average benefits test shall not be satisfied, the amounts allocated to the Dependent Care Spending Accounts on behalf of Participants who are Highly Compensated Employees may be reduced to the extent necessary to satisfy the 55% average benefits test and/or all or a portion of the amounts allocated to the Dependent Care Spending Accounts on behalf of the Participants who are Highly Compensated Employees may be treated as taxable income.

6.10 Definitions

The following terms used in this Article and other documents relating to the Dependent Care Spending Plan shall have the meanings described in this Section.

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

(b) **“Dependent Care Expenses”** means expenses for Dependent Care Services and Household Services which are necessary for the Participant to be gainfully employed.

(c) **“Dependent Care Services”** means dependent care services for a Qualifying Individual which may be performed either inside or outside the Participant's home. However, if the Dependent Care Services are performed outside the Participant's home, the Dependent Care Services must be provided to a Qualifying Individual who also satisfies one of the following requirements:

(1) The Qualifying Individual is a Qualifying Child who is under the age of 13; or

(2) The Qualifying Individual is a spouse or Dependent (regardless of the Dependent's age) who has a Total Disability and regularly spends at least eight hours per day in the Participant's home.

(d) **“Earned Income”** means all income derived from wages, salaries and other Employee Compensation (such as disability benefits). Earned Income does not include any amounts received:

(1) Under the Dependent Care Spending Plan or any other dependent care assistance program under Section 129 of the Code;

(2) As a pension or annuity; or

(3) As unemployment or workers' compensation.

(e) **“Household Services”** means household services performed in and about the Participant's home which are ordinary and necessary to the maintenance of a household and which are attributable in part to the care of a Qualifying Individual. For

example, amounts paid for the services of a domestic maid or cook are expenses for Household Services if part of the services are provided to the Qualifying Individual.

(f) **“Qualifying Child”** means an individual who meets all of the following requirements:

(1) **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, or a brother, sister, stepbrother, stepsister of the Participant or a descendant of any such relative;

(2) **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;

(3) **Financial Support** The individual has not provided over half of the individual’s own financial support for the year;

(4) **No Joint Tax Return** The individual has not filed a joint tax return (other than a claim of refund) with his or her spouse for the year; and

(5) **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 person. The following rules determine who may claim a child as a Qualifying Child for purposes of this 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 persons (where one is a parent and one is a non-parent) for a year shall be treated as the Qualifying Child of the person who is the parent.

(B) **Neither is a Parent** A child that is claimed as a Qualifying Child for tax purposes by two persons (where neither is a parent) for a year shall be treated as the Qualifying Child of the person 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 person who is not a parent has a higher adjusted gross income than any parent. .

(C) **Parents Filing Separate Tax Returns** Except as provided in subparagraph (D), a child of parents who do not file a joint tax return shall be treated as the Qualifying Individual 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 the child's age, shall be treated as a Qualifying Child of the custodial parent (the parent with whom the child shares the same principal residence with 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.

(g) “Qualifying Individual” means:

(1) A Dependent who is a Qualifying Child and who is under the age of 13;

(2) A Dependent who has a Total Disability, regardless of the Dependent's age, and who has the same principal residence as the Participant for more than half of the year; or

(3) 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.

(h) “Qualifying Relative” is an individual who meets all of the following requirements:

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

(2) The Participant provides over half of the individual's financial support for the year; and

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

(i) “Student” means an individual who, during each of five calendar months during a Plan Year, is a full-time student at an educational institution. For purposes of this Article, “educational institution” means a college or university which satisfies the following requirements:

(1) Its primary function is to present formal instruction;

(2) It normally maintains a regular faculty and curriculum; and

(3) It normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly conducted.

(j) **“Total Disability”** means a physical or mental condition which makes a person incapable of caring for his hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his personal safety or the safety of others.

Article 7

Funding

7.1 Funding of Welfare Benefits Plan and Qualified Benefits

Employer shall pay all self-insured benefits and premiums for fully-insured benefits under the Welfare Benefits Plan and for Qualified Benefits and all additional Compensation for waiving health coverage under the Welfare Benefits Plan from its general assets. Nothing in the Plan shall be construed to require Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

7.2 Funding of Flexible Spending Accounts

The Flexible Spending Accounts shall be for bookkeeping purposes only. All benefits shall be paid from Employer’s general assets. Nothing in the Plan shall be construed to require Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

Article 8

Administration

8.1 Powers of Plan Administrator

The Plan Administrator shall have the discretionary authority and power necessary to administer and meet its obligations under the Plan, including, without limitation, the following:

- (a) Interpret the terms and provisions of the Plan.
- (b) Decide all questions of eligibility for participation in the Plan.
- (c) Decide all questions of eligibility for benefit payments and determine the amount and manner of the payment of benefits.
- (d) Make and enforce rules and regulations it deems necessary for the efficient administration of the Plan.
- (e) Pay contributions and premiums under the Plan in a timely manner for all Participants entitled to payment under the Plan and pay expenses incident to the administration of the Plan.

(f) Establish procedures by which Participants may apply for reimbursement under the Plan.

(g) Determine the rights under the Plan of any Participant applying for or receiving reimbursement.

(h) Reimburse all Participants entitled to reimbursement under the Plan in a timely manner.

(i) Administer the appeal procedure provided in this Article.

(j) Delegate specific responsibilities for the operation and administration of the Plan to any Employees or agents.

(k) Maintain records and accounts pertaining to the Plan.

(l) Correct administrative and operational errors and omissions.

8.2 Claims for Benefits

Benefits under the Welfare Benefits Plan shall be paid in accordance with procedures for the submission of claims for benefits established under that plan.

8.3 Appeal Procedure

Any Participant whose claim under the Plan is not paid or is denied, in whole or in part, shall be given notice in writing of the nonpayment or denial by the Plan Administrator. The Plan Administrator shall provide the notice of the nonpayment within 90 days after the payment is due and shall provide the notice of the denial within 90 days after the claim is received by the Plan, unless special circumstances require an extension of time for processing the claim. If an extension of time is required, the Plan Administrator shall provide the Participant written notice of the extension before the expiration of the initial 90-day period. However, in no event shall the extension exceed a period of 90 days from the end of the initial period.

The notice of the nonpayment or denial shall be in easily understood language and shall indicate the reasons for the nonpayment or denial and the specific provisions of the Plan on which the nonpayment or denial is based. The notice shall explain that the Participant may request a review of the nonpayment or denial and the procedure for requesting review. The notice shall describe any additional information necessary to perfect the Participant's claim and explain why the information is necessary.

A Participant may make a written request to the Plan Administrator for a review of any nonpayment or denial under the Plan. The request must be in writing and must be made within 90 days after the mailing date of the notice of nonpayment or denial. The request shall refer to the provisions of the Plan on which it is based and shall set forth the facts relied upon as justifying a reversal or modification of the determination being appealed.

A Participant who requests a review of a nonpayment or denial in accordance with this appeal procedure may examine pertinent documents and submit pertinent issues and

comments in writing. A Participant may have a representative act on his behalf in exercising his right to request a review and the rights granted by this appeal procedure. The Plan Administrator shall provide a review of the decision within 60 days after receiving the written request for review.

Any Participant whose application for benefits under the Welfare Benefits Plan has been denied, in whole or in part, shall have a right to obtain a review of the decision as provided in that plan.

8.4 Standard of Care

The Plan Administrator shall administer the Plan in accordance with the terms of the Plan solely in the interest of the Participants and for the exclusive purposes of providing benefits to Participants and defraying the reasonable expenses of administration of the Plan. The Plan Administrator shall administer the Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator 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. The Plan Administrator shall not be liable for any act or omission by another relating to the Plan.

Article 9

Rights of Participants

9.1 Employment Rights

The existence of the Plan shall not grant a Participant any legal right to continue as an Employee, or affect the right of Employer to discharge a Participant.

9.2 Participants' Rights

The Plan shall be maintained for the exclusive benefit of the Participants and their dependents. However, the existence of the Plan, shall not give any Participant or dependent any equity or other interest in the assets, business or affairs of Employer. Similarly, the existence of the Plan does not give any Participant or dependent the right to challenge any action taken by Employer, or any policy adopted or followed by Employer or the right to examine any of the books and records of Employer.

9.3 Spendthrift Provision

No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest shall be void. No interest shall be liable for or subject to the debts or liabilities of any Participant.

Article 10

Plan Amendment and Termination

10.1 Amendment of Plan

Plan Sponsor may amend the Plan at any time. Any amendment shall be subject to the following:

(a) No amendment shall reduce or eliminate a Participant's right to have his premiums under the Welfare Benefits Plan and for Qualified Benefits paid in accordance with the provisions of the Plan to the extent a Participant has used Compensation Reductions to pay the premiums.

(b) No amendment shall reduce or eliminate a Participant's right to claim reimbursement in accordance with the provisions of the Plan to the extent there are amounts credited to the Participant's Flexible Spending Accounts as of the date of the amendment and to the extent the expense was incurred prior to the date of the amendment.

(c) Each amendment shall be in writing. The terms of the Plan may not be modified by any oral statements made by Employer or any of its directors, officers, Employees, agents or authorized representatives.

Any amendment may be made retroactively effective to the extent permitted by the Code.

10.2 Termination of Plan

Although Plan Sponsor intends to continue the Plan indefinitely, Plan Sponsor reserves the right to terminate or partially terminate the Plan at any time by action of its Board of Education. If the Plan is terminated or partially terminated for any reason, the amount of a Participant's prior Compensation Reductions shall continue to be applied for the exclusive benefit of the Participant and his dependents.

Article 11

Miscellaneous Provisions

11.1 Age

Any reference in the Plan to age shall mean the age of the individual as of the individual's last birthday.

11.2 Uniformity of Treatment

Any action taken under the Plan by the Plan Administrator shall be uniform in its application to similarly situated persons.

11.3 Effect Upon Other Compensation-Related Plans

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

11.4 Construction

Words used in the masculine shall apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural shall be read as the singular and the singular as the plural.

11.5 Governing Law

The provisions of the Plan shall be governed by the laws of the state of Michigan.

Signature

IN WITNESS OF WHICH, Plan Sponsor has adopted the Plan this _____ day of _____, 2010.

THORNAPPLE KELLOGG SCHOOLS

By _____

Its _____