Summary Plan Description

of the

JENISON PUBLIC SCHOOLS
CAFETERIA PLAN

INTRODUCTION

Jenison Public Schools (the "District") maintains the **Jenison Public Schools Cafeteria Plan** ("Plan") for the benefit of its employees. The Plan allows you to design your own benefits package to suit your individual needs.

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the Plan. The Summary Plan Description is based upon the Plan provisions in effect as of January 1, 2018.

You should carefully read this Summary Plan Description and keep it for future reference. This Summary Plan Description does not replace the provisions of the Plan document. The Plan document governs the operation of the Plan. Every effort has been made to make this Summary Plan Description as complete and accurate as possible, without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan document, the terms of the Plan document will control.

If you have any questions about the Plan, please contact Leslie Philipps, Director of Human Resources, Jenison Public Schools Administration Office.

JENISON PUBLIC SCHOOLS

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WHAT IS THE CAFETERIA PLAN?

The Cafeteria Plan is a plan which allows you to design a benefits package to suit the individual needs of you and your family. You may be eligible for the following benefit choices under the Plan:

- If you elect medical coverage under the District's group health plan you must elect to pay your portion of the premium on a pre-tax basis.

- Subject to the terms of the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you, if you are classified as a full-time employee, you may be eligible to receive District-provided dental, vision, group life/AD&D and long-term disability coverage at no cost. If you are classified as a part-time employee, you may be eligible to receive these coverages by paying a prorated portion of the premium on a pre-tax basis.

- You may be eligible to receive short-term disability coverage and additional life coverage, subject to the terms of the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you. You may reduce your compensation on a pre-tax basis to pay the premium for these coverages.

- You may waive District-provided medical coverage and may be eligible to receive additional compensation from the District subject to the terms of the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you.

- If you are only covered by the District's high deductible health plan (and not covered by a non-high deductible health plan, for example, through your spouse's employer), you may elect to reduce your pay to make contributions on a pre-tax basis to your health savings account ("HSA").

More information regarding the types of tax-free benefits which you may choose and the procedures for making your benefit elections are explained in the following sections of this Summary Plan Description.

References are made throughout this Summary Plan Description to the "plan year." Benefits under the Plan are elected on a plan year basis. The plan year is the 12-month accounting period for the Plan, which is January 1 through December 31. Any references to "calendar year" also mean the 12-month consecutive period beginning January 1 and ending on December 31.

References are also made throughout this Summary Plan Description to your "spouse" and your "dependents." For purposes of paying premiums for the coverages mentioned above which include spouses and dependents, the Plan relies on the definitions of those terms in the underlying documents for that coverage. For determining the maximum contribution limits for HSAs, these terms must be defined pursuant to the Internal Revenue Code.

ELIGIBILITY AND PARTICIPATION

Eligibility and Beginning of Participation

If you are a member of a collective bargaining unit or employee benefits group that is eligible for participation in the Plan, you may become a participant in the Plan on the day you become eligible to participate in the District's group health plan and in any other insurance coverages available through the District to the extent provided in the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you.

For the purpose of making pre-tax HSA contributions, you may become a participant in the Plan on first day of any month on or after the date you become enrolled in the District's high deductible health plan and are eligible to make HSA contributions.

Termination of Participation

If you terminate employment with the District, or otherwise become ineligible to participate in the Plan, your participation in the Plan will terminate on the last day you are an eligible employee. For HSA purposes, this means the last day of the month in which you are no longer an eligible employee. Your termination will have the following consequences:

- You will no longer be eligible to use pre-tax income to pay for medical coverage under the District's group health plan or for any other insurance coverages made available by the District.

- You will no longer be eligible to receive additional compensation, if applicable, from the District for waiving District-provided medical coverage.

- You will no longer be eligible to contribute to your HSA by reducing your pay (but you may still make tax deductible contributions directly to the HSA while you are a participant in the District's high deductible health plan (for example, pursuant to COBRA)).

In addition, the District may terminate your participation in the Plan for cause, which includes a termination for fraud or misrepresentation in an application for enrollment or a claim for benefits.

If you are rehired during the same plan year in which you terminate employment, there are special rules which may apply to you. If you become eligible to participate in the Plan again during the same plan year, you should contact Leslie Philipps, Director of Human Resources, Jenison Public Schools Administration Office, for the details regarding these special eligibility rules.

BENEFIT CHOICES

For each plan year, you may choose from the following benefits:

Health Insurance Benefits

The District maintains a group health plan which may provide you, your spouse and your dependents with medical coverage. **The type and extent of your coverage under the District's group health plan will be determined under the terms of the collective bargaining agreement or board policy, handbook or individual employment contract that applies to you.** You may be required to pay a portion of the cost of the medical coverage if you decide to participate. You have two choices with regard to the medical coverage for you, your spouse and your dependents:

- You may elect to receive the medical coverage and pay your share of the cost with your pay reductions.

- You may elect to waive the medical coverage. Certification of other medical coverage is required to waive medical coverage. If medical coverage is waived, the District may pay additional compensation to you subject to the terms of the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you. You will receive additional pay, if applicable, in your paychecks during the plan year for which medical coverage was waived. (The District will inform you of the time table for paying any additional compensation (for example, in equal installments over each pay period or quarterly, in a lump sum at year end, etc.)). Additional compensation is subject to tax withholdings.

Other Insurance Benefits

Subject to the terms of the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you, if you are classified as a full-time employee, you may be eligible to receive District-provided dental, vision, group life/AD&D and long-term disability coverage at no cost. If you are classified as a part-time employee, you may be eligible to receive these coverages by paying a prorated portion of the premium on a pre-tax basis.

Further, you may be eligible to receive short-term disability coverage and additional life coverage, subject to the terms of the collective bargaining agreement or Board policy, handbook or individual employment contract that applies to you. You may reduce your compensation on a pre-tax basis to pay the premium for these coverages.

Health Savings Accounts

If you are **only** covered by the District's high deductible health plan (as that term is defined in the Internal Revenue Code) and not covered by other health insurance, you may use your pay reductions to contribute to an HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section).

COBRA Premiums

If you terminate employment and receive severance pay from the District, you may elect COBRA and pay your COBRA premiums for medical, dental and vision coverage on a pre-tax basis from the severance pay. Further, you may also pay for other available benefits on a pre-tax basis during the severance period.

YOUR PAY REDUCTIONS

You may select different types of tax-free benefits under the Plan by reducing your pay to purchase the benefits. For each plan year, you may elect to reduce your pay for each pay period in an equal amount. Your W-2 Form (which you use to compute your income taxes) will be reduced by the total amount of your pre-tax pay reductions so you will not pay income taxes on this portion of your pay. In addition, your pre-tax pay reductions are not subject to FICA.

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will need medical coverage under the District's group health plan, or any of the other insurance coverages the District makes available to you, or you are eligible to make HSA contributions, you could reduce your pay and obtain the coverage or make the contributions with "before-tax" income rather than "after-tax" income.

A disadvantage is that the pre-tax pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits.

You may elect to reduce your pay as provided in the election process. The election procedures will be provided to you during the open enrollment period (see the "CHOOSING YOUR BENEFITS" section below).

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing benefits under the Plan. You may generally not change your election during the plan year, except as described below.

Initial Benefit Selection

Generally, you must make an election before the date that you become a participant in the Plan. However, if you are a new employee who becomes eligible to participate in the

Plan on your date of hire and you make your election within the next 30 days after you start working, the election will be retroactively effective to your first day of employment. The District will inform you of the election procedures. The election process may require the completion and return of a written election form and/or may require you to make your election electronically such as through an online computer system or telephone system.

Your election will authorize the pre-tax pay reduction necessary for payment of the medical coverage you elect under the District's group health plan or for any other insurance coverage the District may make available to you. All elections must be made on a timely basis. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make an election before the date that you become a participant in the Plan, you will not be eligible to pay your cost of medical coverage under the District's group health plan or for any other insurance coverages available through the District on a pre-tax basis for the remainder of the plan year. Further, you will not be eligible to receive any additional compensation for waiving medical coverage. Instead, you will receive your regular pay for the remainder of the plan year through the District's payroll system.

There are also special election rules regarding your HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section).

Annual Benefit Selection

For each type of benefit, there will be an open enrollment period before the start of each plan year. You may make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment period for that particular benefit or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make a new election during the open enrollment period, your prior elections regarding medical coverage under the group health plan and any other insurance coverages made available by the District will be continued. You will be considered to have agreed to pay the appropriate premium for the subsequent plan year for this coverage. If the current medical insurance election in which you are enrolled is not being offered during the subsequent plan year, you will be enrolled in the most similar option.

There are special election rules regarding your HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section).

CHANGING YOUR ELECTION DURING A PLAN YEAR

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain situations for which federal law permits a new election. These rules do not apply to an HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section). The next sections describe these situations.

Change In Status

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;
- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;
- An event affecting the employment status of you or your spouse or dependent, including a termination or a 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;
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, or any similar circumstance; or
- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Plan only if the election change is on account of, and corresponds with, the change in status that affects eligibility for coverage. However, the following special rules apply:

- If you want to decrease or cancel District-provided medical, dental and vision coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.
- With respect to any group term life insurance or disability benefit election, an election to increase or decrease coverage will be permitted.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not make a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

Changes to Coordinate with Health Care Reform

Under Health Care Reform, you may become eligible for District-provided group medical coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of less than 30 hours of service per week. If this occurs, you can elect to cancel District-provided group medical coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage in this situation for yourself and any affected family members provided that you enroll in another plan that provides "minimum essential coverage" (as that term is defined under Health Care Reform) which is effective no later than the first day of the second month following the month that includes the date your District-provided group medical coverage is revoked.

Similarly, if you are eligible to enroll in a "qualified health plan" (as that term is defined under Health Care Reform) through an Exchange during a special enrollment period or annual open enrollment period, you can elect to cancel District-provided group medical coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan which is effective no later than the day immediately following the date your District-provided group medical coverage is revoked.

FMLA Leaves and Other District-Approved Leaves of Absence

If you go on an FMLA leave, you may continue or revoke your elections regarding group medical, dental and vision coverage even if you do not otherwise have a change in status. If you go on an FMLA leave, the following rules apply:

- Generally, the maximum FMLA leave period is 12 weeks per 12-month period (as that 12-month period is defined by the District). However, if you take an FMLA leave 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.

- You may continue or revoke your election of group medical, dental and vision coverage when you begin your FMLA leave.

- If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact Leslie Philipps, Director of Human Resources, Jenison Public Schools

Administration Office to discuss the procedures for making the contributions.

- If you terminated coverage during the FMLA leave, your coverage may be reinstated when you return to work. Reinstatement will occur immediately.

- You have the same election rights as an actively working participant during an open enrollment period and if a new or significantly improved benefit or coverage option is offered.

- If you take an unpaid FMLA leave and you receive additional compensation from the District for waiving medical coverage, you will not receive this additional compensation for the time period when you are on the unpaid leave.

- If you do not return to work at the end of an FMLA leave, your participation in the Plan may terminate.

The rules described above will also apply if you go on a non-FMLA District-approved leave of absence (including a District-approved leave after you have exhausted FMLA).

Special Enrollment Rights Under HIPAA

You may have special rights under HIPAA to enroll in the District's group medical plan in these situations:

- You have lost other group medical coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

- You acquire a new dependent by marriage, birth or adoption. You must make your new election within 30 days after the event occurs.

- Your Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or you become eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain medical coverage under the District's group health plan. ("CHIP" is a state children's health insurance program.) You must make your new election within 60 days after the event occurs.

Court Order

You may change your election regarding the medical, dental and vision coverage available through the District because of a court order resulting from a divorce, legal separation or change in legal custody that requires coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the District-provided medical, dental and vision coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

Medicare or Medicaid Coverage

If you, your spouse or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce medical coverage for that individual under the District's group health plan. In addition, if you, your spouse or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase medical coverage for that individual under the District's group health plan.

Cost and Coverage Changes

If the cost of medical coverage under the District's group health plan or one of the District's other insurance plans in which you participate changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either, agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. (Certification of other medical coverage is required in order to drop coverage (see the "BENEFIT CHOICES" section).) Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

If medical coverage under the District's group health plan or one of the District's other insurance plans in which you participate is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. (Certification of other medical coverage is required in order to drop coverage (see the "BENEFIT CHOICES" section).) Further, if the District offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under this Plan.

YOUR PRE-TAX PREMIUM PAYMENTS

If you elect to receive medical coverage under the District's group health plan or under the other insurance plans provided by the District, your pay will be reduced by the amount stated in your

election. Your premiums will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you must make arrangements with the District to pay your share of the premiums in order to continue coverage.

YOUR HEALTH SAVINGS ACCOUNT ("HSA")

What is an HSA?

An HSA is a tax-favored IRA-type account established for an eligible individual (see the subsection below regarding who is eligible). Contributions to an HSA are fully vested when made and investment earnings are not taxable when earned. Distributions from the HSA are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years. This Plan provides a mechanism for you to make pre-tax contributions to an HSA.

Who is Eligible to Participate in an HSA?

You will be eligible to make contributions to an HSA if you satisfy two requirements:

- You participate in the District's high deductible health plan ("HDHP") (as that term is defined in the Internal Revenue Code) with an annual minimum deductible of at least the amounts determined by law; and

- You do **not** participate in any health plan that is **not** an HDHP. You will **fail** to satisfy this requirement if:

    - You participate in a "traditional" health plan (for example, through the District or your spouse's employer); or

    - You participate in a medical spending account (for example, through your spouse's employer) that permits reimbursement of all types of medical claims. If your spouse has a medical spending account through his/her employer, your spouse should check with his/her employer regarding how the medical spending account coordinates with your HDHP coverage.

How Can I Make HSA Contributions Through the Plan?

You may make pre-tax pay contributions (pay reductions) to your HSA through the Plan.

You may elect to make pre-tax contributions to your HSA as of your initial date of eligibility. If you do not make an election within a reasonable period of time before your initial date of eligibility, you may do so as of any later date based upon the procedures established by the plan administrator.

The normal initial and annual election procedures of the Plan do not apply to HSAs, nor do the restrictions on making mid-year election changes. Once you make an election, it

will remain in force (including for subsequent plan years) unless you make a change. You can elect to increase, decrease, stop or begin pre-tax HSA contributions at least monthly, as of any prospective date, based upon procedures established by the plan administrator.

Who Administers My HSA?

An HSA must be held by a trustee or custodian (such as a bank). The District will inform you of the trustee or custodian it has selected for your HSA. If you elect to contribute to an HSA, the District will forward the contributions to the trustee or custodian. The money in the HSA will be invested by the trustee or custodian. The trustee or custodian will provide you with more information regarding how your HSA balance will be invested and any election opportunities you have with respect to the investments.

Is There a Limit on My Contributions?

The IRS limits the HSA contributions you may make each calendar year. The maximum amount depends on whether you are enrolled in single/employee-only or family coverage. The maximums may be adjusted each year for changes in the cost-of-living.

If you will be at least age 55 by December 31, your maximum annual HSA contribution limit for the calendar year will be increased under a special catch-up rule. This amount may also be adjusted in future years for changes in the cost-of-living.

Will the District Make Contributions to My HSA?

The District does not currently contribute to your HSA.

How Can I Access My HSA Funds?

Once you establish an HSA, it may be accessed by following the procedures established by the trustee or custodian. You will be issued a debit card to use for this purpose. Alternatively, you will also typically be allowed to submit a written reimbursement request form to the trustee or custodian.

Amounts in your HSA can be distributed to cover your deductible requirements under the HDHP. You can also use your HSA money to pay for eligible health care expenses not covered by the HDHP. Amounts distributed for health care expenses are tax-free. You can also request a distribution for other purposes. For expenses other than eligible health care expenses, the amount distributed is taxable income and is also subject to a 20% penalty tax. But in certain circumstances the 20% penalty tax may be waived (such as for individuals who are disabled or at least age 65).

Amounts in your HSA can be distributed on a tax-free basis to cover your deductibles and other eligible health care expenses of you and your spouse. However, amounts can only be reimbursed on a tax-free basis to cover deductible and eligible health care expenses of your children and other dependents where they are your qualifying child or qualifying relative. In other words, if you have an older child (for example, age 25) who

is covered under the HDHP as a result of the new definition of older dependent child required by health care reform, his or her out-of-pocket expenses will not be eligible to be reimbursed under the HSA on a tax-free basis unless the child is otherwise your tax dependent (i.e., qualifying child or qualifying relative).

What if I Change Jobs?

HSAs are permanent and portable. You can take your HSA with you to your next job. You can continue to grow the dollars in your account through investment or use the monies for eligible health care expenses. However, in order to actively contribute to an HSA, you must be covered under a qualified HDHP either through your new employer or an individual policy.

What Happens to My HSA after I Turn Age 65?

After you reach age 65, your HSA can be used to pay eligible health care expenses and certain insurance premiums like Medicare Parts B and D. Monies cannot be used to purchase a Medigap policy. Distributions for eligible health care expenses are tax-free. Distributions for other expenses are taxable.

The Plan only provides a way for contributions to be made to your HSA. As a result, the other rules concerning the HSA and the District's HDHP are not part of this Plan but will be provided to you in the communications materials regarding the HSA and HDHP benefits.

ADMINISTRATION

The District is the plan administrator. The plan administrator is charged with the administration of the Plan. The plan administrator has the authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The plan administrator will exercise its discretionary authority in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the plan administrator has the discretionary authority to interpret the terms of the Plan.

FUTURE OF THE PLAN

The District intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan at any time. However, your pay reductions which occur before the amendment or termination will continue to be used for your benefit.