Elkton-Pigeon-Bay Port Lakers Schools Cafeteria Plan

SUMMARY PLAN DESCRIPTION

Effective July 1, 2013

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Summary Plan Description
With Premium Payment, and HSA Components

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Summary Plan Description

Article I
INTRODUCTION

Elkton-Pigeon-Bay Port Lakers Schools, (the "Employer") sponsors the Elkton-Pigeon-Bay Port Lakers Schools Cafeteria Plan (with Premium Payment, and HSA Components) (the "Cafeteria Plan") that allows Eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. Alternatively, Eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This Summary Plan Description (SPD) describes the basic features of the Cafeteria Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Cafeteria Plan and is not meant to interpret or change the provisions of your Plan. A copy of your Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the Cafeteria Plan document and this Summary, the Cafeteria Plan Document shall govern.

Article II
PARTICIPATION IN YOUR PLAN

How can I participate in the Cafeteria Plan?
Once an Employee has met the Plan's eligibility requirements, and provided that the election procedures outlined under **'How do I become a Participant and when is my Entry Date?'** section are followed, the Eligible Employee may participate in the Plan.

What are the Eligibility Requirements to participate in the Plan?
Employees who are eligible to participate in the Employer's group medical insurance and are employed by a participating Employer may participate in the Plan once they meet the eligibility requirements and provided that the election procedures outlined under '**How do I become a Participant?**' section are followed.

Eligibility for the Premium Insurance Benefits is also subject to the additional eligibility requirements, if any, specified in the Medical Insurance Plan.

Eligibility for HSA Benefits also requires that you be an "HSA-Eligible Individual." See **'What are HSA Benefits?'.**

Are there any Employees who are not eligible to participate in the Plan?
The following Employees are excluded from participating in the Plan: self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

How do I become a Participant and when is my Entry Date?
After you satisfy the eligibility requirements described under **'What are the Eligibility Requirements to participate in the Cafeteria Plan?',** you may enter the plan on the date the eligibility requirements have been met by signing an individual Election Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement will be available by the first day of the Open Enrollment Period. You must complete the Election Form/Salary Reduction Agreement and return it to Mike Klosowski within the time period specified in the enrollment materials. (If you have not received the enrollment materials and/or the Election Form/Salary Reduction Agreement, ask Mike Klosowski for copies.) An Eligible Employee who fails to complete, sign, and return an Election Form/Salary Reduction Agreement, (or waiver of pre-tax premiums) as required, for the first plan year is considered to have elected **not** to participate for the initial Plan Year and may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under **'Can I change my elections under the Cafeteria Plan during the Plan Year?'.**

An Eligible Employee who fails to complete, sign, and return an Election Form/Salary Reduction Agreement, (or waiver of pre-tax premiums) as required, for subsequent Plan Years, then the Employee shall continue with the same elections as the prior year for insured/premium benefits.

If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Premium Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as explained under **'Can I change my elections under the Cafeteria Plan during the Plan Year?'),** a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

Employees who actually participate in the Cafeteria Plan are called "Participants." An Employee continues to participate in the Cafeteria Plan until: (a) termination of the Cafeteria Plan; or (b) the date on which the

Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

What is the "Open Enrollment Period" and the "Plan Year"?
The Open Enrollment Period is the period during which you have an opportunity to participate under the Cafeteria Plan by signing and returning an individual Election Form/Salary Reduction Agreement.

You will be notified of the timing and duration of the Open Enrollment Period prior to the beginning of the new Plan Year. The Plan Administrator will inform all Participants of the applicable dates for each annual enrollment period.

What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?
If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for the Premium insurance benefits, and HSA benefits.

The Premium Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

See '**What is Continuation Coverage and how does it work?**' and the booklets for the Medical Insurance Plan for information on your right to continued or converted group health coverage after termination of your employment.

For information about obtaining distributions from your HSA at any time, including after termination of employment, contact the trustee/custodian of your HSA established and maintained outside of the Plan.

If you are rehired within 30 days or less during the same Plan Year and are eligible for the Cafeteria Plan, then your prior elections will be reinstated.

If you are rehired more than 30 days after you terminated employment, and are eligible for the Cafeteria Plan, you will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, you may rejoin the Plan without having to complete the waiting period before again becoming eligible to participate in the Plan again.

How does a leave of absence (such as under FMLA) affect my benefits?

Non-FMLA Leaves of Absence
If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid:

* with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
* with their share of premium payments on the same schedule as payments would be made if the Employee were not on leave, or under another schedule permitted under Department of Labor regulations; or
* under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see **'When Can I Change Elections Under the Cafeteria Plan During the Plan Year?').**

Article III
PAYING FOR YOUR BENEFITS UNDER YOUR PLAN

How do employees pay for benefits on a pre-tax basis?
An Employee's election to pay for benefits on a pre-tax or after-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer (ask Mike Klosowski for a copy if you have not received one). Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Are there Employer contributions to the Plan?
Your Employer may make contributions to the Plan, in addition to your Salary Reduction, as provided in the open enrollment materials furnished to you and/or on the Election Form/Salary Reduction Agreement.

Flex Credits Formula
Employee□s waiving employer sponsored group medical, dental or vision coverage will receive cash-in-lieu of the benefit

Will I pay any administrative costs under the Cafeteria Plan?
No. The cost of the plan includes administrative expenses and is paid entirely by the Employer.

Can I change my elections under the Cafeteria Plan during the Plan Year?
With the exception of HSA Benefits (for which prospective election changes generally are allowable), you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various "Change in Election Events" that are described under '**When Can I Change Elections Under the Cafeteria Plan?**'. The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

When can I change elections under the cafeteria plan during the Plan Year?
Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various 'Change in Election Events' headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined under '**How do leaves of absence (such as under FMLA) affect my benefits?**'); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees,

and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence.

If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence
(Applies to Medical Insurance Benefits)
You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described under **'How do leaves of absence (such as under FMLA) affect my benefits?'**

2. Change in Status.
(Applies to Medical Insurance Benefits) If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

* a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
* a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
* any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
* an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, or a similar circumstance); or
* a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status-Other Requirements.
(Applies to Medical Insurance Benefits)
If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility.

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

* *Loss of Spouse or Dependent Rules.* For accident and health benefits (the Medical Insurance Plan), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual

other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one dependent coverage would be consistent with this Change in Status.

* *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

4. Special Enrollment Rights. *(Applies to Medical Insurance Benefits)* In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you. Contact the Human Resources Manager if you need another copy.) When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. *(Applies to Medical Insurance Benefits)* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to Medical Insurance Benefits)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits, as applicable).

7. Change in Cost. *(Applies to Medical Insurance Benefits)* If the cost charged to you for your Medical Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of Medical Insurance benefits.

8. Change in Coverage. *(Applies to Medical Insurance Benefits)* You may also change your election if one of the following events occurs:

* *Significant Curtailment of Coverage.* If your Medical Insurance Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage.)

* *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

* *Loss of Other Group Health Coverage.* You may prospectively change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP); a medical care program of certain Indian Tribal programs or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

  An election change on account of a HIPAA special enrollment attributable to an employee or dependent becoming eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 60 days).

* *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

9. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this section, '**When Can I Change Elections Under the Cafeteria Plan During the Plan Year?**'.

Article IV
WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

What benefits may be elected under the Cafeteria Plan?
The Cafeteria Plan includes the following benefit plans:

Premium Payment Component (currently including Premium Insurance Benefits) - permits an Employee to pay for his or her share of contributions for the Medical Insurance Plan with pre-tax dollars. "Medical Insurance Plan" means the major medical plan that your Employer maintains for Employees, their Spouses, and Dependents, providing major medical type benefits through a group insurance policy.

Here, these benefits include Basic Health, Dental, and Disability Benefits options. Benefits provided under the Medical Insurance Plan are called "Premium Insurance Benefits." Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called "Premium Payment Benefits";

Health Savings Account (HSA) - permits an Employee to make pre-tax contributions to an HSA established and maintained outside of the Plan with the Employee's HSA trustee/custodian. Benefits provided under the HSA, which consist solely of the ability to contribute to the HSA on a pre-tax salary reduction basis, are called "HSA Benefits"; and

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Article V
HOW BENEFITS ARE TAXED

What tax savings are possible under the Cafeteria Plan?
You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Premium Insurance Benefits under the Cafeteria Plan. Suppose that you are married and have one child and that your share of the required contributions for Premium Insurance Benefits for family coverage is an annual total of $6,400. Suppose also that your gross pay is $75,000, your Spouse (a student) earns no income, and you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce $6,400 to pay for the Premium Insurance contributions, then your annual take-home pay would be $57,252. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only $55,802. This is because by participating in the Cafeteria Plan for Premium Insurance contributions, you will be considered for tax purposes to have received $68,600 in gross pay, so you save $1,450 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

Caution: The amount of the contributions used in this example is not meant to reflect your actual contributions—the actual contribution amounts will be determined by you.

	Cafeteria Plan*	No Cafeteria Plan
1. Adjusted Gross Income	$75,000	$75,000
2. Salary Reductions for Premiums	($6,400)	$0
3. W-2 Gross Wages	$68,600	$75,000
4. Standard Deduction	($11,400)	($11,400)
5. Exemptions	($10,950)	($10,950)
6. Taxable Income (line 3 minus lines 4 & 5)	$46,250	$52,650
7. W-2 Gross Wages	$68,600	$75,000
8. Federal Income Tax (line 6 @ tax schedule)	($6,100)	($7,060)
9. FICA Tax (7.65% of line 3)	($5,248)	($5,738)
10. After-Tax Premium Payments	$0	($6,400)
11. Pay After Taxes and Premium Payments (line 7 minus lines 8, 9 & 10)	$57,252	$55,802

* Based on the standard deduction, exemptions, and federal income tax rates for 2010, as found in IRS Rev. Proc. 2009-50, 2009-45 I.R.B. 167. The FICA tax rate is found at http://www.ssa.gov/pressoffice/factsheets/colafacts2010.htm (as visited November 8, 2010).

How will participating in the Cafeteria Plan affect my Social Security and other benefits?
Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits.

Will I be taxed on the HSA Benefits that I receive?
You may save both federal income taxes and FICA (Social Security) taxes by participating in the Cafeteria Plan. However, very different rules apply with respect to taxability of HSA Benefits than for other Benefits

offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA see the communications materials provided by your HSA trustee/custodian and see IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

The Employer cannot guarantee that specific tax consequences will flow from your participation in the Cafeteria Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Remember that the Plan Administrator is not providing legal advice.

Article VI
PREMIUM INSURANCE BENEFIT ACCOUNT

What are "Premium Payment Benefits"?
As described under '**How do employees pay for benefits on a pre-tax basis?**', if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Premium Insurance Benefits with pre-tax dollars by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See '**How Benefits Are Taxed?**'.

The only Premium Payment Benefits offered under your Plan are for Premium Insurance Benefits, this is major medical insurance, including Basic Health, Dental, and Disability Benefits options.

How are my Premium Payment Benefits paid?
As described under '**How do employees pay for benefits on a pre-tax basis?**' and '**What are "Premium Payment Benefits?**', if you select the Medical Insurance Plan described under '**What are Premium Payment Benefits?**', then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Article VII
HEALTH SAVINGS ACCOUNT (HSA)

What are "HSA Benefits"?
A Health Savings Account permits Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Employee's HSA trustee/custodian. For purposes of this Cafeteria Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under this Cafeteria Plan. As described under '**How do employees pay for benefits on a pre-tax basis?**', if you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See '**What tax savings are possible under the Cafeteria Plan?**' for an example dealing with pre-tax payments of Premium Insurance contributions.

To participate in the HSA Benefits, you must be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Code § 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer. ("High Deductible Health Plan" means the high deductible health plan offered by your Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials that will be provided separately to you by the Employer.) If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage and you should be aware that coverage under a Spouse's plan could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans"). In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax salary reductions through the Employer's payroll system to your designated HSA trustee/custodian.

What is my "HSA"?
The HSA is not an employer-sponsored employee benefit plan-it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code § 223. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. The HSA trustee/custodian will be chosen by you, as the Participant, and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pre-tax salary reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your HSA is administered by your HSA trustee/custodian. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax Salary-Reduction basis. Your Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified above is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

HSA funds can be withdrawn for nonmedical reasons, but such nonmedical distributions are included in gross income and are generally subject to an additional 20% excise tax as of January 1, 2011.

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

How are my HSA Benefits paid for under the Cafeteria Plan?
When you complete the Election Form/Salary Reduction Agreement, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution for such

coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

For example, suppose that you have elected to contribute up to $1,000 per year for HSA Benefits and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of $1,000 during the Plan Year. If you are paid biweekly, then our records would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the HSA Benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

The Employer makes no contribution to your HSA.

As described under **'What is my HSA?',** your Employer has no authority or control over the funds deposited in your HSA.

What are the maximum HSA Benefits that I may elect under the Cafeteria Plan?
If an individual is an HSA-eligible individual for only part of the year, but you meet all of the requirements under Code §223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family).

(1) The sum of the limits determined separately for each month under §223(b)(2), based on eligibility and HDHP coverage on the first day of each month, plus catch-up contributions for each month, if applicable; or
(2) The maximum annual HSA contribution under §223(b)(2)(A) or §223(b)(2)(B) based on the individual's HDHP coverage (self-only or family) on the first day of the last month of the individual's taxable year, plus catch-up contributions under §223(b)(3), if applicable.

For calendar year 2013, the annual limitation on deductions under §223(b)(2)(A) for an individual with self-only coverage under a high deductible health plan is $3,250. For calendar year 2013, the annual limitation on deductions under §223(b)(2)(B) for an individual with family coverage under a high deductible health plan is $6,450.

For calendar year 2013, a "high deductible health plan" is defined under §223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,250 for self-only coverage or $2,500 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,250 for self-only coverage or $12,500 for family coverage.

An additional catch-up contribution ($1,000 for 2013 and thereafter) may be made if you are age 55 or older (you must certify your age to your Employer).

In addition, the maximum annual contribution shall be reduced by any matching (or other) Employer contribution made on your behalf (as described under **'What are HSA Benefits?'**).

Who can contribute to an HSA under the Cafeteria Plan?
Only Employees who are HSA-Eligible Individuals can participate in the HSA Benefits. As described under ' **What are HSA Benefits?**', an HSA-Eligible Individual means an individual who meets the eligibility requirements of Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage. The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer.

Can I change my HSA Contribution under the Cafeteria Plan?

As under **'When Can I Change Elections Under the Cafeteria Plan?',** you may increase, decrease, or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements. (See **'What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?')**

Where can I get more information on my HSA and its related tax consequences?
For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

Article VIII
CLAIMS PROCEDURE

What happens if my claim for benefits is denied?

Premium Insurance Benefits

The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (review outside of the plan). For more information about how to file a claim and for details regarding the medical insurance company's claims procedures, consult the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for the Medical Insurance Plan.

HSA Claims Not Involving Issues Relating to Salary Reductions

Claims relating in any way to the HSA established and maintained by you outside of the Plan with your HSA trustee/custodian (for example, issues involving the investment or distribution of your HSA funds) shall be administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and such trustee/custodian.

Appeals

If your claim is denied in whole or part, then you (or your authorized representative) have the right to an internal appeal and, if applicable, an external review to an independent review organization. You may request review upon written application to the "Appeals Committee" for an internal review.

You will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit. In fact, as explained later in this summary, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.

Requirements for an Internal Appeal

Your internal appeal must be in writing, must be provided to the Administrator, and must include the following information:

* Your name and address;
* The fact that you are disputing a denial of a claim or the Administrator's act or omission;
* The date of the notice that the Administrator informed you of the denied claim; and
* The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

Deadline for Filing an Internal Appeal

Your internal appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. If you do not file your internal appeal within this 180 day period, you lose your right to appeal. Your internal appeal will be heard and decided by the Committee.

Decision on Review

Anytime before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Committee. The Cafeteria Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim.

If your internal appeal is denied, the notice that you receive from the Committee will include the following information:

* Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
* The specific reason for the denial upon review;
* A reference to the specific Plan provision(s) on which the denial is based;
* Any denial code (and its corresponding meaning) that was used in denying the claim;
* A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
* If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

You have the right to an external review of the Administrator's denial of your internal appeal of the Health FSA claim unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

Requirements for an External Appeal
You may request an external appeal by completing the form provided to you by the Administrator which must include the following information:

* Your name, address, daytime telephone number and email address; and
* A brief description of why you disagree with the decision, along with any additional information, such as a physician's letter, bills, medical records, or other documents to support your claim.
* Return the Request for External Review and your denial notice as instructed on the form.

You should also include any documentation that you have not already provided to the Administrator.

Deadline for filing an External Appeal
Your external appeal must be filed with the external reviewer within four (4) months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, 2012, you must appeal the decision by May 3, 2012 (or, if that is not a business day, the next business day thereafter).

The plan must complete a preliminary review within five (5) business days upon receipt of your external review request to determine if you were covered under the plan, you provided all of the necessary

information to process the external review and that you have exhausted the internal appeals process. The plan must provide you with a written notice of its preliminary review determination within one (1) business day after completing its review. If your request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide you with the Employee Benefits Security Administration (EBSA) contact information. If your request is incomplete, the notice must describe the information or materials needed to complete the request. The plan must permit you to "perfect" (i.e., complete) the external review request within the four-month filing period or, if later, 48 hours after receipt of the notice.

Decision on Review of External Appeal
The plan must assign an accredited Independent Review Organization to perform the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Duty of Beneficiary/Third Party Recoveries
Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

Subrogation/Acts of Third Parties
The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

Article IX
FUNDING

Funding This Plan
The Benefits provided herein shall be paid for in part by the Employer and in part under Salary Reduction Agreements.

All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

A separate HSA trustee/custodial fee may be assessed by your HSA trustee/custodian for your HSA established and maintained by you outside of the Plan.

How long will the Cafeteria Plan remain in effect?
Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

Article X
GENERAL INFORMATION

What other general information should I know?
This question contains certain general information that you may need to know about the Plan. **Note:** This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan.

Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

General Plan Information

* Name: Elkton-Pigeon-Bay Port Lakers Schools Cafeteria Plan
* Plan Number: 501
* Effective Date: July 1, 2013
* Plan Year: September 6th to June 30th. Your Plan's records are maintained on this 12-month period of time.
* Type of Plan: Fringe Benefit and Welfare plan providing Benefits
* Your plan shall be governed by the Laws of the State of Michigan

Employer/Plan Sponsor Information

* Name and Address: Elkton-Pigeon-Bay Port Lakers Schools
  6136 Pigeon Rd
  Pigeon, MI 48755
  (989) 453-4602
* Federal Employer Tax Identification Number (EIN): 38-6035303

Plan Administrator Information
Name, address, and business telephone number:

Elkton-Pigeon-Bay Port Lakers Schools
6136 Pigeon Rd
Pigeon, MI 48755
(989) 453-4602

The Plan Administrator appoints the Benefits Administrator to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The Benefits Administrator will answer any questions that you may have about our Plan. You may contact the Benefits Administrator at the above address for any further information about the Plan.

Funding and Type of Plan Administration
All of the amounts payable under this Plan may be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy.

Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Agent for Service of Legal Process
The name and address of the Plan's agent for service of legal process is:

Elkton-Pigeon-Bay Port Lakers Schools
6136 Pigeon Rd
Pigeon, MI 48755
(989) 453-4602

Michelle's Law
"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA (Genetic Information Non-Discrimination Act) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)
Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
This new law amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

Medical Insurance Plan and HSA Documents and Information
This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan.

Neither does this Summary Plan Description describe many aspects of the HSA Component (e.g., with respect to claims and reimbursement under the HSA). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.