

Second Amended & Restated

FLEXIBLE BENEFIT PLAN

**SUMMARY
PLAN
DESCRIPTION**



**MICHIGAN
CATHOLIC**
CONFERENCE

*Second
Amended &
Restated*

**FLEXIBLE
BENEFIT
PLAN**

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DESCRIPTION**

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Introduction

Your employer has adopted the Section 125 Church Flexible Benefit Plan (“Plan”). As part of this Plan, your employer may also have adopted the Michigan Catholic Conference Medical Expense Reimbursement Plan and/or the Michigan Catholic Conference Dependent Care Assistance Plan (“Flex Accounts”). The Michigan Catholic Conference established the Flex Accounts as a service to the employees of participating employers who are associated with or under the control of seven Catholic Dioceses of Michigan that comprise the Conference. The purpose of this Plan is to give employees the flexibility to reduce their taxable cash compensation in order to obtain certain nontaxable dependent care benefits, medical expense reimbursement benefits or medical benefits and other insurance benefits as adopted by your Employer in the Adoption Agreement for the Section 125 Church Flexible Benefit Plan (“Adoption Agreement”).

Some of the benefits provided on a pre-tax basis are provided under separate plans or programs (e.g., group health plan). This summary generally does not provide the full detail of these other benefit plans. For information on such plans, please consult the separate summaries for such plans. This Summary Plan Description does, however, describe the benefits available under the Dependent Care Assistance Program and Medical Expense Reimbursement Plan in full detail and shall constitute the Summary Plan Description for those benefit arrangements to the extent such a summary is required by law.

This Summary Plan Description has been prepared to generally explain the provisions of the Plan. It does not give the full details of the Plan, nor any separate plans or programs of the employer. This Summary Plan Description is not meant to interpret, extend, or change the Plan in any way. In case of a conflict between this Summary and the actual provisions of the formal Plan document, the provisions of the Plan document will control.



Basic Information

Name of Plan:

Section 125 Church Flexible Benefit Plan.

Name and address of Plan Sponsor and Plan Administrator of Flex Accounts:

Michigan Catholic Conference, 510 South Capitol Avenue, P.O. Box 10157, Lansing, MI 48901; (517) 372-9310.

Name and address of the Contract Administrator of the Flex Accounts:

Meritain Health, P.O. Box 30111, Lansing, MI 48909; (800) 748-0003.

Michigan Catholic Conference Employer Identification Number:

38-1708700.

Type of Plan:

Cafeteria plan.

Effective date of Plan:

Plan benefits were previously provided under the Michigan Catholic Conference Flexible Benefit Plan which was effective January 1, 1991. However, this Plan is effective January 1, 2013.

Agent for Service of Legal Process:

Michigan Catholic Conference, 510 South Capitol Avenue, P.O. Box 10157, Lansing, Michigan 48901; (517) 372-9310.

Note: Service of legal process may also be made on the Plan Administrator.

Type of Administration of the Plan:

As set forth in the Plan.

Plan Year:

The Plan Year starts on January 1 and ends on December 31.

Rules for Eligibility and Participation in the Plan

1 When am I eligible to participate in the Plan?

If you normally work more than 20 hours or more per week for your Employer, you shall be eligible to participate in the portions of the Plan adopted by your Employer as reflected in the Adoption Agreement. Additionally, you will only be eligible to participate in the Medical Expense Reimbursement Plan if you are also eligible to participate in major medical coverage under your Employer's group health plan.

As discussed in C-2 below, the date you can begin participation varies with respect to the different benefits offered.

Although your Spouse and Dependents may not participate in this Plan, they may benefit from your participation. The term "Dependent" generally means a Participant's Spouse and any person who is a dependent of the Participant within the meaning of Code section 152 (however, for health benefits, a Dependent generally means any person who is a dependent as defined as set forth in Code sections 105(b), 106 and the regulations and other authority thereunder). The term "Spouse" means an individual who is legally married to a Participant as determined under applicable Michigan state law and who is treated as a spouse under the Code. Please see the underlying benefits to determine Dependent eligibility.

2 When will my participation begin?

Premium Sharing Benefits

With respect to the Premium Sharing Benefits under the Plan (which permit you to pay the employee portion of your health or dental coverage premiums with pre-tax dollars) you shall immediately begin participation upon satisfying the eligibility requirements.

Medical Expense Reimbursement and Dependent Care Assistance Benefits

With respect to the Medical Expense Reimbursement and Dependent Care Assistance benefits available under the Plan, you shall begin participation on the first day of the next Plan Year following the date you satisfy the eligibility requirements outlined in C-1 above.

3 When will my participation end and under what circumstances will it be reinstated?

Generally, your participation in the Plan will end when you lose eligibility under the Plan, you cease employment with the Employer, the Plan terminates or you revoke your election as provided in the Plan. However, if you transfer employment as a full-time Employee to another Covered Unit as set forth in the Plan you will not be deemed to have terminated employment for purposes of the Medical Expense Reimbursement and Dependent Care Assistance Accounts. You will continue your current elections in the account(s) if the change in employment status does not otherwise affect your eligibility for coverage.

Rules for Eligibility and Participation in the Plan

Except as indicated below, if your participation ended and you again become eligible, you may begin participation at the time provided in C-2. If you terminate employment for any reason, including, but not limited to, disability, retirement, layoff or voluntary resignation, and then are rehired within 30 days or less of the date of a termination of employment, you will be reinstated in this Plan accordingly to your previous elections and will not be allowed to make a new election. If you terminate employment and are not rehired within 30 days or cease to be eligible for any other reason, including, but not limited to, a reduction in hours, you must complete the eligibility requirements described in C-1 before again becoming eligible to participate in the Plan. A new election may then be made.

4 How will participating in the Plan affect my Social Security and other benefits?

Participation in the Plan will reduce the amount of your taxable compensation, which could cause 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 Plan participation will often more than offset any reduction in other benefits.

5 What happens to my coverage if I take leave under the Family and Medical Leave Act (FMLA)?

If you take leave under the Family and Medical Leave Act (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your medical and dental insurance and Medical Expense Reimbursement Plan coverage on the same terms and conditions as if you were still actively working (that is, your Employer will continue to pay its' share of the premium to the extent you opt to continue coverage). Typically, you will have the choice to continue coverage during your FMLA leave, or to revoke coverage. However, in some circumstances, your Employer may require that coverage be continued during your FMLA leave.

If you are taking a paid FMLA leave, your Employer may elect to continue your medical and dental insurance and Medical Expense Reimbursement Plan coverage, so long as Participants on non-FMLA paid leave are required to continue coverage. In this case, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis, if that is what was used before the FMLA leave began).

If you are taking an unpaid leave and your Employer requires all Participants to continue medical and dental insurance and Medical Expense Reimbursement Plan coverage, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, as you and the Employer may agree.

Rules for Eligibility and Participation in the Plan

If you choose to continue your medical and dental insurance and Medical Expense Reimbursement Plan coverage, on either a paid or unpaid FMLA leave, then you may continue to pay your share of the premium in the following ways:

- (a) You may prepay your contributions due for the FMLA leave period prior to taking your leave. Contributions under the pre-pay option may be made on a pre-tax salary reduction basis or on an after-tax basis (to pre-pay in advance, you must make a special election before such compensation would normally be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year));
- (b) You may pay your contribution during your leave as if you were not on leave. These payments may be made with after-tax dollars, or with pre-tax dollars if you receive compensation during the leave for any allowable unused sick days and vacation days; or
- (c) You may pay your contribution by other arrangements agreed upon between you and the Employer. For example, you and your Employer may agree that the Employer pay for coverage during the leave and then will withhold amounts from your compensation upon your return from leave to “catch-up” on the payment you owe.

If your medical and dental insurance or Medical Expense Reimbursement Plan coverage ceases while on FMLA leave (e.g., for revocation or nonpayment of required contributions), you will be entitled to re-enter such benefits, applicable, upon return from such leave on the same basis you were participating in the Plan before the leave, or otherwise required by the FMLA. If your Medical Expense Reimbursement Plan coverage ceases, you will be entitled to elect whether to be reinstated in the Medical Expense Reimbursement Plan at the same coverage level as in effect before FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Medical Expense Reimbursement Plan coverage will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, your election for nonhealth benefits (such as Dependent Care Assistance Program benefits) will be treated in the same way as under Employer’s policy for providing such benefits for Participants on a non-FMLA leave. If that policy permits Participants to discontinue contributions while on leave, Participants will, upon returning from leave, be required to repay the premiums not paid by the Participant during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Employer and the Participant or as the Employer otherwise deems appropriate.

Rules for Eligibility and Participation in the Plan

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 premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Employer.

6 What happens to my coverage if I enter or return from military service?

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may have special rights to health care coverage under your Medical Expense Reimbursement Plan. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

Benefits Available Under the Plan

1 What benefit options are available under the Plan?

Your Employer adopted this Plan to provide you with the flexibility to elect among permitted taxable benefits and qualified nontaxable benefits offered through this Plan for the Plan Year. Specifically, you may elect to receive your normal compensation in cash or to reduce that compensation to receive Employer-provided coverage on a pre-tax basis for the following benefits only if adopted by your Employer as set forth in the Adoption Agreement:

- (a) Premium Payment options, including medical and dental coverage under your Employer's Group Health and Group Dental Plan or other benefit plans (which are incorporated by reference);
- (b) Dependent Care Assistance benefits; and
- (c) Medical Expense Reimbursement benefits.

The Coverage Period for each of the above described benefits you elect is the Plan Year, with the following exceptions:

- (a) when you first become eligible to participate, it shall mean the portion of the Plan Year coinciding with and following the date participation commences, as described in C-2; and
- (b) if you terminate participation, it shall mean the portion of the Plan Year prior to and including the date participation terminates, as described in C-3.

2 Can I pay for Group Health and/or Group Dental coverage with pre-tax dollars under the Plan? Alternatively, if I waive coverage, can I elect to receive a cash payment?

If your Employer has elected to participate in the Premium Sharing Benefits in the Adoption Agreement, yes, the Plan will allow you to reduce your pay in pre-tax dollars to make the required employee contribution to purchase coverage under your employer's Group Health Plan and/or Dental Plan as set forth in the Adoption Agreement. The amount your compensation is reduced to purchase these benefits will not be subject to federal, state or local income taxes or FICA taxes. This benefit is referred to as the "Premium Sharing Benefit." Although you may make an election to receive this benefit under this Plan, the group plan benefits will be provided by separate plans governed by separate plan documents.

Alternatively, if your Employer has elected to participate in the Employer Compensation Account in the Adoption Agreement, yes, the Plan will permit you waive medical coverage under the Employer's Group Health Plan and elect a cash payment in an amount allowed by the Employer. This is only available if you are eligible for your Employer's Group Health Plan and only if you provide proof of coverage through an alternative medical insurance carrier. Additionally, you must complete and return the Cash Payment Election Form prior to the beginning of the Plan Year (or for new Participants, prior to the first pay period) for which the Participant's election will apply. If you lose the alternative

Benefits Available Under the Plan

coverage or experience a change in election event described in Article G, you will be permitted as the Group Health Plan allows to revoke this election and make a new election mid-Plan Year; otherwise, your election is irrevocable for the Plan Year. Upon revocation, the cash payment shall cease.

Please see the Adoption Agreement to the Section 125 Church Flexible Benefit Plan for more details.

3 Can I purchase Dependent Care Assistance Benefits with pre-tax dollars under the Plan?

If your Employer has elected to participate in the Dependent Care Assistance Account in the Adoption Agreement, yes, the Plan will allow you to reduce your compensation each pay period and have the amount of the reduction credited to a Dependent Care Assistance Account for your benefit. You can then draw on your account during the Plan Year for reimbursement of Qualifying Dependent Care Expenses, as defined in D-8, incurred by you during the Plan Year. Expenses are incurred when the service is provided, not when the expense is paid. Please note that any unused amounts remaining in your Dependent Care Assistance Account at the end of the Plan Year must, by federal law, be forfeited. Any reimbursements you receive for Qualifying Dependent Care Expenses will be excluded from your taxable income. The amount that your compensation is reduced to purchase these benefits will not be subject to federal, state, or local income taxes or FICA taxes. Please see the Adoption Agreement to the Section 125 Church Flexible Benefit Plan for more details.

4 What is my limitation on Dependent Care Assistance Benefits?

The reimbursement (when combined with all other reimbursements received by you under the Plan during the same taxable year) may not exceed your Account Balance, nor the least of the following limits:

- (a) Your earned income for the calendar year (only wages, salary or other employee compensation that is includable in gross income for the taxable year).
- (b) If you are married, your spouse's actual or deemed earned income.
- (c) \$5,000 (\$2,500 in the case of a separate return filed by a married person as defined in Code section 21(e)).

For purposes of (b) above, your spouse will be deemed to have earned income of \$250 (\$500 if you have two or more dependents), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student at an educational institution.

5 Can I purchase Medical Expense Reimbursement Benefits with pre-tax dollars under the Plan?

If your Employer has elected to participate in the Medical Expense Reimbursement Account in the Adoption Agreement, yes, the Plan will allow you to reduce your compensation by an amount up to \$2,500 per Plan Year and have the amount of the reduction credited to a Medical Expense Reimbursement Account for your benefit. You can then draw on your account during the Plan Year

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for reimbursement of Qualifying Medical Care Expenses, as defined in D-10, incurred by you or your dependents during the Plan Year. With the exception of advance payments for orthodontia, Qualifying Medical Care Expenses are incurred when the service is provided, not when the Expense is charged or paid (with regard to orthodontic expenses specifically, proof of payment and a copy of the orthodontic contract is also required). The amount by which you elect to have your cash compensation reduced for the entire Plan Year will be immediately credited to your account as of the first day of the Plan Year. Please note that any unused amounts remaining in your Medical Expense Reimbursement Account at the end of the Plan Year must, by federal law, be forfeited. Any reimbursements you receive for Qualifying Medical Care Expenses will be excluded from your taxable income. The amount that your compensation is reduced to purchase these benefits will not be subject to federal, state, or local income taxes or FICA taxes. Please see the Adoption Agreement to the Section 125 Church Flexible Benefit Plan for more details.

6 Who is entitled to the allocations in my account(s)?

The Dependent Care Assistance Account and the Medical Expense Reimbursement Account are created for record keeping purposes only to keep track of contributions and to determine forfeitures. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer and/or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer and/or the Administrator from which any payment under the Plan may be made.

7 How much will my salary be reduced?

This is entirely up to you. Based on your own situation you should decide what amount, if any, you would like to have withheld from your salary and applied on the Employer's books toward each of the optional benefits available to you. In making this decision you should realize that any amounts remaining in both your Dependent Care Assistance Account and your Medical Expense Reimbursement Account after you have been reimbursed for all Qualifying Dependent Care and Medical Care Expenses incurred during the Plan Year will, as required by federal law, be forfeited. You should also be aware that amounts designated for one type of account may not be used to make reimbursements of another type. Thus, for example, amounts you allocate to your Dependent Care Assistance Account cannot be used to reimburse you for Qualifying Medical Care Expenses.

8 What are Qualifying Dependent Care Expenses?

Under the Plan, if applicable, you will be reimbursed only for dependent care expenses meeting all of the following conditions:

Benefits Available Under the Plan

- (a) The expenses are incurred for services rendered after the date that you make an election to receive Dependent Care Assistance and during the Plan Year to which it applies.
- (b) Each individual for whom you incur the expenses is:
 - (1) your dependent (who is a qualifying child within the meaning of the Internal Revenue Code Section 152) who has not attained age 13, or
 - (2) your spouse or dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of such taxable year.

However, in circumstances of legally separated or divorced parents or parents who live apart at all times during the last six months of the calendar year, a child as described in this subsection (b) and in Code Sections 21(e)(5) and 152(e) will be the “dependent” of the parent having custody for the greater portion of the calendar year.

- (c) The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you (and your spouse) to be gainfully employed, with the exception for short, temporary absences. If your spouse is not working or actively looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care. The expenses must be incurred when at least one member of your household meets (b)(1) or (b)(2) above.
- (d) The expenses are not paid or payable to a child of yours (within the meaning of Section 152(f)(1) who is under age 19 at the end of the year in which the expenses are incurred, to an individual for whom you or your spouse are entitled to a personal tax exemption as a dependent, to your spouse, or to the parent of your child as described in (b)(1) above.
- (e) If the expenses are incurred for services outside your household, they will be reimbursed if the dependent who is described in (b)(1) above, or the spouse or dependent who is described in (b)(2) above, regularly spends at least eight hours per day in your household. The expenses may not be paid for services outside your household at a camp where the dependent stays overnight.
- (f) If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

9 **Would I be better off taking the Child Care Tax Credit rather than reducing my salary and electing Dependent Care Assistance?**

You will need to carefully examine your own tax situation to determine this. For more information about how the Child Care Tax Credit works, see IRS Publication No. 503, located on-line at www.irs.gov.

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irs.gov. Please use this publication with caution because it was meant to help taxpayers figure out if they can claim the Dependent Care Tax Credit and not what is reimbursable under a Dependent Care Assistance Program. Some statements in the publication are not correct for determining whether an expense is reimbursable from the Dependent Care Assistance Program. You will not be able to claim a tax benefit for the amounts received by you under the Plan, although if you incur expenses in excess of your Account and below your limitation for the year, you may be able to claim a credit for the excess amount.

You and your tax advisor should calculate the tax savings that are available through use of the credit and compare it to the tax savings you would enjoy by reducing your salary under the Plan. If you have any questions about whether or not an expense is reimbursable, ask the Administrator.

10 What are Qualifying Medical Care Expenses?

The term “Qualifying Medical Care Expenses” means expenses incurred during the Coverage Period by the individuals described below for medical care as defined in Code section 213(d), as limited by section 213(b), but only to the extent that you or other persons incurring the expense are not reimbursed for the expense through insurance or otherwise. If only a portion of the Medical Care Expense has been reimbursed elsewhere, the Plan may reimburse the remaining portion of the expense if it otherwise meets this definition. Furthermore, you may not be reimbursed for “qualified long-term care services” as defined in Code section 7702B(c) or any premium payments for health care coverage. Qualifying Medical Care Expenses are incurred at the time the services to which the expense relates are rendered, regardless of when you are charged for the services. Qualifying Medical Care Expenses shall include expenses incurred for a medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

Qualifying Medical Care Expenses include, for example, expenses you have incurred for:

- (a) Medicine and drugs if such medicine and drugs are prescribed drugs or insulin.
- (b) Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- (c) Medical examination, x-ray and laboratory service, and insulin treatment the doctor ordered.
- (d) Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
- (e) Hospital care (including meals and lodging), clinic costs and lab fees.
- (f) Inpatient medical treatment at a center for drug addicts or alcoholics (including meals and lodging).
- (g) Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.

Benefits Available Under the Plan

- (h) Weight-loss program participation expenses only if the purpose of participation is to treat a specific disease or diseases as diagnosed by a physician. Diet food items are not a Qualifying Medical Care Expense.
- (i) Ambulance service and other travel costs to get medical care. If you used your own car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim mileage at the rate listed in IRS Publication 502, located on-line at www.irs.gov. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

- (a) The basic cost of Medicare insurance (Medicare A).
- (b) Life insurance or income protection policies.
- (c) The hospital insurance benefits tax withheld from your pay as part of the social security tax or paid as part of social security self-employment tax.
- (d) Nursing care for a healthy baby.
- (e) Illegal operations, treatments or drugs.
- (f) Travel your doctor told you to take for rest or change.
- (g) Funeral expenses.
- (h) Insurance premiums.
- (i) Long-term care expenses.
- (j) Medicine and drugs that are not prescribed or are not insulin (i.e., over-the-counter).
- (k) Any medical expense which would violate the tenets of the Catholic Church, specifically including medical expenses relating to sterilizations, abortions, and/or birth control devices.

Qualifying medical expenses include only those expenses incurred for:

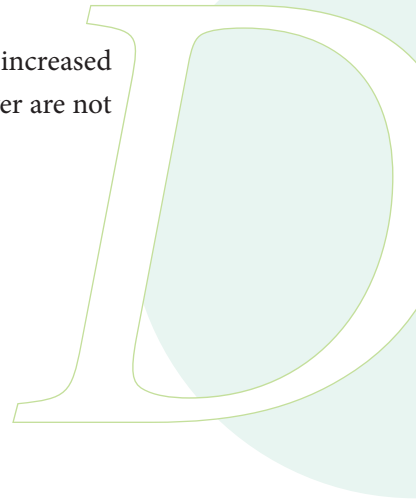
- (a) Yourself.
- (b) Your spouse.
- (c) Your dependents (as defined in Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B)). Effective January 1, 2011, the definition of “Dependent” for purposes of this Section is expanded to include an adult child only until the end of the month in which the child turns 26 years of age. A “child” for this purpose is as defined in Code section 152(f)(1). The definition of “child” for this purpose shall not include a child of your child.

IRS Publication 502, Medical and Dental Expenses, located on-line at www.irs.gov, has a checklist of medical expenses that can be deducted and those that cannot. Please use this publication with caution because it was meant to help taxpayers figure out their tax deductions and not what is reimbursable under a Medical Expense Reimbursement Account. Some statements in the publication are not correct for determining whether an expense is reimbursable from the Medical Expense Reimbursement Account.

Benefits Available Under the Plan

11 Are medical expenses for which I receive reimbursement eligible for a tax deduction?

Generally, individuals can only deduct medical expenses to the extent they exceed 7.5 percent (increased to 10 percent in 2013) of their adjusted gross income. Expenses reimbursed by your employer are not counted towards meeting this threshold and would not otherwise be deductible.



Purchasing Alternative Benefits Through Salary Reduction

1 How do I reduce my salary in order to purchase alternative benefits with pre-tax dollars?

When you first become eligible and prior to the beginning of each Plan Year thereafter, your Employer will provide you with an election form and salary reduction agreement for you to complete to receive the optional benefits under this Plan and only as adopted by your Employer in the Adoption Agreement. This form must be completed and returned to your Employer prior to the beginning of the Plan Year when your election becomes effective, or, for new participants in the Premium Sharing and/or Employer Compensation Account portions of the Plan, prior to the first day of the first pay period that your election will become effective as stated in the election form. Unless otherwise agreed, you will pay for your share of the cost of coverage by having a portion of the cost deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck).

2 What happens if I fail to return the election form to the Administrator?

If you fail to return a completed election form to the Administrator by the due date, you will be deemed not to participate in the Plan for the upcoming Plan Year and will be unable to purchase any optional benefits by salary reduction for the Plan Year. These deemed elections will remain in effect unless one of the events described in Section G occurs to justify a mid-year election change.

3 How will the Michigan Catholic Conference pay the Dependent Care or Medical Care Expenses?

The Michigan Catholic Conference has retained the Contract Administrator to pay the expenses by reimbursing you directly after you provide the required information.

4 What happens if I terminate employment in the middle of the year?

If you cease participation in the Plan for any reason, you will also cease participation in the Medical Expense Reimbursement and Dependent Care Assistance Programs. With regard to the Medical Expense Reimbursement Program, you may not make additional contributions and you may only be reimbursed for claims incurred during your participation in the Plan. The total amount credited to the former Participant's Medical Expense Reimbursement Account (minus previous reimbursements) shall be available to the former Participant for reimbursements if the former Participant applies for reimbursement on or before the 90th day after the Participant's termination of participation. All claims for reimbursement must be submitted to the Contract Administrator within 90 days following termination to be eligible for reimbursement.

Additionally, you may not make additional contributions to the Dependent Care Assistance Program after your participation ceases. However, the total amount credited to your Dependent Care Assistance Account (minus previous reimbursements) shall be available to you for claims that incur during the remainder of the Plan Year. Only claims incurred during your participation in the Plan and for the remainder of that Plan Year may be reimbursed. You must apply for reimbursement on or before the 90th day after the close of the Plan Year in which your termination occurred. In essence, the Plan will allow you to spend down the remaining balance in your account for claims that occur until the end of the Plan Year.

Claims Procedure for Dependent Care and Medical Care Expenses

1 How do I make a claim for reimbursement of a Dependent Care Expense or a Medical Care Expense?

If you have elected to receive Dependent Care Assistance or Medical Expense Reimbursement coverage for a Plan Year, you may apply to the Contract Administrator for reimbursement of expenses incurred during the year by submitting an application, in writing, stating the following:

- (a) the amount, date and nature of the expense with respect to which a benefit is requested;
- (a) the name of the person, organization or entity to which the expense was or is to be paid and the taxpayer identification number (Social Security Number, if an individual);
- (a) the name of the person on whose behalf the Expense was incurred and if the person is not the Participant, the person's relationship to the Participant;
- (a) the amount recovered, or expected to be recovered, under any insurance arrangement or other plan; and
- (b) any other information as the Employer or Contract Administrator may require, including bills, invoices, receipts, canceled checks or other statements of the Expense. With regard to orthodontic expenses specifically, proof of payment and a copy of the orthodontic contract is required.

If you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Contract Administrator. If the Contract Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

2 What are the time periods for determination of claims?

The Contract Administrator will give notice to you of the amount of benefits payable under the Plan within 15 days after receipt of a claim involving non-urgent care by the Plan, unless you have failed to submit sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator will notify you of the specific information necessary to complete the claim within 5 days after receipt of the claim by the Plan. You must provide this additional information within 45 days after receipt of the notice from the Plan. The Contract Administrator will notify you of the Plan's determination within a reasonable time after the earlier of the Plan's receipt of the specified additional information, or the end of the 45 days that you had to provide the information, but in no event will the determination be later than 15 days after the earlier of those two dates. The Contract Administrator will give notice to you of the amount of benefits payable under the Plan within 72 hours after receipt of a claim involving urgent care by the Plan, unless you have failed to submit sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator

Claims Procedure for Dependent Care and Medical Care Expenses

The Plan will notify you of the specific information necessary to complete the claim within 24 hours after receipt of the claim by the Plan. You must provide this additional information within 48 hours after receipt of the notice from the Plan. The Contract Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the 48 hours that you had to provide the information. If you do not agree with the decision, within 180 days after receiving notification of the amount of benefits payable, you may file a claim with the Contract Administrator objecting to the benefits payable from the Plan. Within 30 days after submission of a claim involving non-urgent care, you will be given written notice of whether the claim is wholly or partially denied. Within 72 hours after submission of a claim involving urgent care, you will be given written notice of whether the claim is wholly or partially denied. You may not undertake any legal action with respect to a claim until all rights under the claims procedure have been exhausted.

Changes in Election

1 Can I change or revoke my elections during the Plan year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections mid-Plan Year, if the underlying benefit plan allows. You are permitted to change elections if you have a “change in status” event, as determined by the Plan Administrator, and you make an election change that is on account of and consistent with the event, and within 30 days of the event. New elections will take effect as determined by the Administrator, but no earlier than the first pay period after you return the change in election form. Federal law considers the following events to be “changes in status” if they affect eligibility for coverage:

- (a) Marriage, divorce, death of a spouse, legal separation or annulment;
- (b) Change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent;
- (c) Any of the following changes in employment status for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in work site or any other change in employment status that affects eligibility for benefits;
- (d) One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status or any similar circumstance; and
- (e) A change in the place of residence of you, your spouse or dependent.

2 Are there any exceptions to the changes in status rules?

If you are participating in the Dependent Care Assistance Program, there is a change in status if your dependent no longer meets the eligibility qualifications for dependent care.

Additionally, if you transfer employment as a full-time Employee to another Covered Unit as set forth in the Plan you will not be deemed to have terminated employment for purposes of the Medical Expense Reimbursement and Dependent Care Assistance Accounts as long as both employers participate in the account(s). You will continue your current elections in the account(s) if the change in employment status does not otherwise affect your eligibility for coverage.

3 When is a change in election consistent with a change in status?

There are detailed rules on when a change in election is deemed to be consistent with a “change in status.” In addition, there are laws that give you rights to change accident and health coverage for you, your spouse or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

Changes in Election

Generally, a change in election is not consistent with a change in status if it is your divorce, annulment or legal separation, the death of your spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage and your election is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if your spouse or dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then your election to cease or decrease coverage for that individual corresponds with the change in status only if coverage for that individual becomes applicable or is increased under the family member plan. The Administrator may rely on your certification of other coverage unless there is reason to believe your certification is incorrect.

4 Can I change or revoke my elections due to a change in cost or coverage?

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then your Employer will automatically increase or decrease, as the case may be, your cafeteria plan election. If the cost increases or decreases significantly, you will be permitted to make corresponding changes in your elections, including commencing participation in the Plan for a significant cost decrease. For a significant cost increase, you may revoke your election and obtain coverage under another benefit package option with similar coverage on a prospective basis, or if there is no option that provides similar coverage, to revoke your election entirely.

If the coverage under a benefit is significantly curtailed during a Plan Year, then you may revoke your elections and elect to receive, on a prospective basis, coverage under another plan with similar coverage. If your coverage is curtailed and you lose coverage, you may revoke your election and elect to receive, on a prospective basis, coverage under another Plan with similar coverage or to drop coverage if no similar coverage is offered. In addition, if your Employer adds a new coverage option or eliminates an existing option, you may elect the newly added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan.

There are also certain situations when you may be able to change your elections on account of a change under another employer plan. Specifically, you may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if

- (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under the final regulations; or
- (b) the period of coverage under this Plan is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

Changes in Election

However, no change is permitted under the Medical Expense Reimbursement Program. Also, you may make a prospective election change to add Group Health coverage for yourself, your spouse or dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool or a foreign government group health plan.

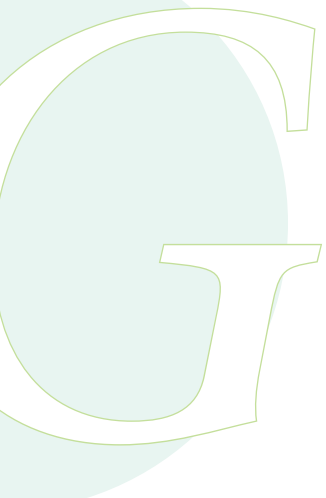
You may not change your election under the Medical Expense Reimbursement Plan if you experience a change in cost or coverage for insurance. You also may not change your election under the Dependent Care Assistance Program if the cost change is imposed by a dependent care provider who is your relative.

5 What are HIPAA Special Enrollment Rights?

An Employee or Participant may revoke an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code section 9801(f). Unless otherwise provided, such change shall take place on a prospective basis.

- (a) As required by HIPAA, a 30-day special enrollment right will arise if:
 - (1) A current Employee is eligible for, but declined enrollment in, this group health plan coverage (or a Dependent of such Employee is eligible for, but was not enrolled in, this group health plans coverage) because the Employee or Dependent was covered under another group health plan or had other health insurance coverage when this group health plan coverage was previously offered and the other coverage was lost due to either: (i) if the other coverage was COBRA continuation coverage, that coverage has been exhausted; or (ii) if the other coverage was not COBRA continuation coverage, either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment; in the case of an HMO, the individual no longer resides, lives or works in the service area where the HMO provides benefits and, in cases of the group market, no other package is available to the individual; an individual incurs a claim meeting or exceeding a lifetime limit on all benefits; or the plan no longer offers any benefits to the class of similarly situated individuals that includes the individual), or employer contributions towards such coverage were terminated. Unless otherwise provided in the Employer's Group Health Plan, the eligible Employee must request enrollment not later than 30 days after the loss of other coverage (or after a claim is denied due to the operation of a lifetime limit on all benefits). Any eligible Dependent may only enroll if that Dependent (or the Employee) meets the above requirements; or

Changes in Election

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- (2) A new Dependent is acquired as a result of marriage, birth, or adoption or placement for adoption, and the group health plan makes coverage available with respect to a Dependent of a Participant or an Employee who has met any waiting period requirements and is eligible to participate under that plan.

Unless otherwise provided in the Employer's Group Health Plan, election changes must be made within 30 days of the date of the marriage, birth or adoption or placement for adoption (or the date dependent coverage is made available, if later). An election to add the following individuals (if otherwise eligible for coverage under the Plan) as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption is consistent with the special enrollment right: (i) a current Employee who is eligible but not enrolled; (ii) a current Employee who is eligible but not enrolled, and the Spouse of such Employee; (iii) a current Employee who is eligible but not enrolled, and the newly acquired Dependent of such Employee; (iv) the Spouse of a Participant; (v) a current Employee who is eligible but not enrolled, and the Spouse and newly acquired Dependent; and (vi) a newly acquired Dependent of a Participant.

Enrollment applications received after the special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Unless otherwise provided in the Employer's Group Health Plan, coverage under the special enrollment period for timely submitted requests must be effective no later than the first day of the month after the plan or issuer receives the request for special enrollment. However, with regard to enrollment requests made within 30 days on behalf of a new Dependent acquired due to birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption (or the date the plan makes dependent coverage available, if later). The prospective increased salary reduction is permitted to reflect the cost of the retroactive coverage under the group health plan from the date of birth, adoption, or placement for adoption.

- (b) As required by HIPAA, effective April 1, 2009, a 60-day special enrollment right will arise if the Employee or Dependent is eligible for, but not enrolled in, the Plan and either:
 - (1) is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for coverage; or
 - (2) becomes eligible for premium assistance, with respect to coverage under the Plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

Changes in Election

The Employee or Dependent with the special enrollment right under subsection (b) must request enrollment within the first 60 days from the date of termination of such coverage under (b)(1) or 60 days from the date the applicant is determined to be eligible for premium assistance under (b)(2). Enrollment applications received after the 60-day special enrollment period will not be considered and the next opportunity to enroll will be at open enrollment. Coverage under this Plan shall take effect on the same date coverage for this HIPAA special enrollment right takes effect in the underlying Employer's Group Health Plan.

6 Can I change or revoke my election due to a court order?

A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) which requires accident or health coverage for your child allows:

- (a) the Plan to change an election to provide coverage for the child if the order requires coverage under your plan; or
- (b) you to change an election to cancel coverage for the child if the order requires the former spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.

7 Can I change or revoke my election due to FMLA leave?

If you take leave under FMLA, as described in C-5, you may revoke an existing election of coverage and make a new election for the remaining period of coverage as provided under FMLA. If you revoke your election, you may also have a right to be reinstated in the same group health plan coverage upon returning from your FMLA leave.

8 Can I change or revoke my election due to eligibility for Medicare or Medicaid?

You may change elections to cancel your health coverage or your spouse's or dependent's coverage if you or your spouse or dependent are enrolled in your employer's accident or health coverage and become entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you or your spouse or dependent have been entitled to Medicaid or Medicare coverage and lose eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage. See also G-5.

9 Can the Administrator change participant elections?

The Administrator may decrease your election if you are Highly Compensated Employee as defined in the Code to prevent the Plan from becoming discriminatory.

Forfeiture of Account Balances

1 Under what circumstances will my Dependent Care Assistance and Medical Expense Reimbursement Account balances be forfeited?

The amount credited to your Dependent Care Assistance Account for any Plan Year can only be used to reimburse you or pay for Dependent Care Expenses incurred during the Plan Year and only if you apply for reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in your Dependent Care Assistance Account for any Plan Year after all reimbursements and payments under the Dependent Care Assistance Plan, it will not be carried over to reimburse you for Dependent Care Expenses incurred during a subsequent Plan Year. **You will forfeit all rights with respect to the balance of the Dependent Care Assistance Account.** The balance shall remain the property of the employer and/or the Administrator and may also be used to defray reasonable administrative costs.

The amount credited to your Medical Expense Reimbursement Account for any Plan Year can only be used to reimburse you or pay for Qualifying Medical Care Expenses incurred while you were a participant during the Plan Year, and only if you apply for reimbursement on or before the earlier of:

- (a) the 90th day following the termination of your participation; or
- (b) the 90th day following the close of the Plan Year.

If any balance remains in your Medical Expense Reimbursement Account for any Plan Year after all reimbursements and payments, it will not be carried over to reimburse you for Medical Care Expenses incurred during subsequent Plan Year. **You will forfeit all rights with respect to the balance of the Medical Expense Reimbursement Account.** The balance shall remain the property of the employer and/or the Administrator and may also be used to defray reasonable administrative costs.

IMPORTANT EXCEPTION REGARDING QUALIFIED RESERVIST DISTRIBUTIONS: If, however, you are a member of a reserve component (as defined in section 101 of title 37, United States Code) and are ordered or called to active duty for a period in excess of 179 days or for an indefinite period, then you may take a Qualified Reservist Distribution in cash. A “Qualified Reservist Distribution” is a taxable distribution of the unused amounts remaining in the Medical Expense Reimbursement Account (i.e., actual payroll deductions minus year-to-date reimbursements) and must be made during the period beginning on the date of such order or call to active duty and ending on the last day of the Plan Year.

Plan Administration

1 How is the Plan administered?

The Medical Expense Reimbursement Plan and the Dependent Care Assistance Plan are administered by the Michigan Catholic Conference, which is designated as the Administrator for those purposes. The Administrator is responsible for maintaining records of the Plan and Participants and for interpreting the Plan in the course of administration. The Administrator has retained a Contract Administrator, Meritain Health, to assist in the administration of the Plan and to assist in processing claims.

2 Who pays the costs of the Plan?

The costs of the Plan are paid by the Administrator from the general assets of the Employer and forfeitures of Participant Accounts.

3 Can benefits or payments under the Plan be assigned?

No. Generally, benefits and payments under this Plan cannot be assigned or alienated. However, there is a limited exception that applies if the Plan receives a “Qualified Medical Child Support Order.” The medical expense reimbursement benefits under the Plan can be assigned to a child of a Participant pursuant to a court-approved property settlement agreement or court order if the requirements set forth in the Plan are met. A medical child support order must satisfy certain specific conditions to be “qualified.” The terms of the Plan outline the required criteria. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Administrator. Additionally, your rights to reimbursement may be subject to assignment to the State in the event you have received Medicaid and/ or Medicare benefits for your medical expenses.



Amendment or Termination of the Plan

1 Can the Plan be amended or terminated?

Although the Employer intends to continue the Plan indefinitely, it reserves the right to amend or terminate the Plan or to modify the Plan to reduce, increase or modify any and all of the benefits provided under the Plan. Any decision to amend, terminate or modify the Plan shall be made by written instrument by the Board of Directors or by any person or persons authorized by the Board of Directors to take such action. This decision shall be communicated to all participants. In the event the Plan is terminated, all elections and reductions in compensation made under the Plan shall terminate, and allowable reimbursements or payments shall be made in accordance with the next paragraph.

2 If the Plan terminates, how will reimbursements or payments for Medical Care or Dependent Care Expenses be made?

If the Plan terminates, you will be entitled to payment or reimbursement for Dependent Care or Medical Care Expenses incurred during the Plan Year if you apply for reimbursement or payment on or before the 90th day after termination of the Plan. Your reimbursement will not exceed the remaining balance, if any, in your Dependent Care Assistance Account or your Medical Expense Reimbursement Account for the Plan Year in which the expenses were incurred.

3 Are benefits under the Plan insured?

The benefits provided under this Plan are simply the tax savings benefits which result from a Participant making elections to pay for the benefits with pre-tax dollars. Thus, the pre-tax benefits under the Plan are not insured by an insurance company or under Title IV of the Employee Retirement Income Security Act of 1974 because that law does not apply. Instead, the Plan is funded by the Employer's assets. Additionally, the benefits under the Plan are not insured under Title IV of the Employee Retirement Income Security Act of 1974 ("ERISA") because that law does not apply. The Plan is funded by the Employer's assets and it is a "church plan" which is not subject to ERISA.



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