The BESTflex™ Plan
Employee Benefits Corporation

Amendment of the Plan Adoption Agreement

Secure upload at: **www.ebcflex.com**
Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126**, 608 831 8445
E-mail support: **employerservices@ebcflex.com**

Chequamegon School District (770158)	26-4009277
Employer	Federal Employer ID Number (FEIN) (xx-xxxxxxx)

Validation

Plan Design changes must be submitted before your Plan starts. Please return ALL pages.
ALL Plan Design changes are subject to review and approval by Employee Benefits Corporation. A $50 fee will be charged for mid-year changes. Plan Renewal changes will be processed at no additional charge up through two weeks following the start of your new plan year.

Changes cannot be made retroactively and some changes are not allowed mid-Plan Year.
This amendment must be signed and dated prior to the effective date of the change in order to be processed.

Authorization

The undersigned, as an authorized representative of the Employer hereby certifies that on

11-01-2013 (Date (mm-dd-yyyy)) the governing body[1] of the Employer adopted the following resolutions:

WHEREAS, the Employer had maintained for the benefit of its employees and their beneficiaries a Section 125 cafeteria plan (the Plan) with the name of

Choose only one option:

- ○ [Employer Name] Flexible Compensation Plan
- ◉ Previously established custom name:

Chequamegon School District Flexible Benefit Plan
Enter the custom Plan name

WHEREAS, the Employer wishes to amend the Plan pursuant to the Employer's amendment authority as set forth in the Plan Document.

NOW, THEREFORE, BE IT RESOLVED, that the Employer hereby amends the Plan as follows, effective 01-01-2014
Effective date of the change (mm-dd-yyyy)

INSTRUCTIONS: Please check the box in the appropriate section and enter the information completely.
Leave the section blank and do NOT check the box if there are no changes.

☐ Change Collectively Bargained Benefit

☐ Yes, this benefit is collectively bargained ☐ No, this benefit is not collectively bargained

☐ Change Plan Year

If the new start date is before the current plan year's end date, the current plan will be shortened.
If the new start date is after the current plan year's end date, a short initial plan year will be created.

☐ Use a calendar Plan Year (January 01 - December 31) beginning January 1, 20 ☐☐

☐ Use an off-calendar Plan Year. The new plan year end date will be 12 months later.

☐☐☐☐☐☐☐☐☐☐
New Plan Year Start Date (mm-dd-yyyy)

[1] Board of directors, in the case of a corporation. Voting partners in the case of a partnership. Managers in the case of a limited liability.

☐ Change Group Premium Accounts

	Renewal Month (mm-dd)	Add	Remove
Medical Insurance		☐	☐
Health Savings Account (HSA) contributions		☐	☐
Dental Insurance		☐	☐
Disability		☐	☐
Group Term Life Insurance (up to $50,000/Employee only)		☐	☐
Other: Insurance type name		☐	☐

	Renewal Month (mm-dd)	Add	Remove
Accidental Death and Dismemberment Insurance		☐	☐
Cancer Insurance		☐	☐
Accident		☐	☐
Hospital Indemnity		☐	☐
MA Commonwealth Connector Benefits/Individual Medical Insurance		☐	☐
Other: Insurance type name		☐	☐

☐ Change Flexible Spending Accounts

	Add	Remove
Health Care FSA	☐	☐
Limited Health Care FSA	☐	☐
Dependent Care FSA	☐	☐
Individual Billed Premium Account	☐	☐

☐ Change 2-1/2 Month Grace Period

	Add	Remove
Health Care FSA/Limited Health Care FSA	☐	☐
Dependent Care FSA	☐	☐
Individual Billed Insurance Premium	☐	☐

☐ Change Flexible Spending Accounts Annual Limits

Health Care and Limited Health Care FSA

$ ☐☐☐☐ ☐ No minimum
Minimum election amount (0000)

$ ☐☐☐☐ ☐ Statutory maximum
Maximum election amount (0000)

Dependent Care FSA

$ ☐☐☐☐ ☐ No minimum
Minimum election amount (0000)

Individual Billed Insurance Premiums Account

$ ☐☐☐☐ ☐ No minimum
Minimum election amount (0000)

☐ Change Employer Contributions

☐ None ☐ Group Premiums ☐ Health Care FSA ☐ Limited Health Care FSA ☐ Dependent Care FSA
☐ All ☐ Individual Billed Premium Account

$ ☐☐☐☐
Amount (0000)

Eligibility:

☐ **Change Employer Contributions** (cont.)

☐ Health Savings Account (HSA)

$ ____ Single
Amount (0000)

$ ____ Family
Amount (0000)

$ ____ Other: _____
Amount (0000)

$ ____ Other: _____
Amount (0000)

Frequency: ○ Pay Period ○ Monthly ○ Quarterly ○ Annually-Plan Start ○ Other: _____

☐ **Change Cash-in-lieu of Insurance Premiums**

Health Insurance: ○ No ○ Yes

$ ____
Amount (0000)

Frequency: ○ Pay Period ○ Monthly ○ Quarterly ○ Annually-Plan End ○ Annually-Plan Start ○ Other: _____

Other Insurance Type: ○ No ○ Yes

Type: _____

$ ____
Amount (0000)

Frequency: ○ Pay Period ○ Monthly ○ Quarterly ○ Annually-Plan End ○ Annually-Plan Start ○ Other: _____

☑ **Change Eligibility Requirements**

Hourly Requirement: 30 Hours per week Other: _____

Waiting Period:

● First of the month after:
- ○ 30 days ○ 60 days ○ 90 days ● Date of hire
- ○ Other: _____

○ From date of hire:
- ○ 30 days ○ 60 days ○ 90 days
- ○ Other: _____

○ On date of hire

○ Other: _____

Other Requirement: _____

Please Sign and Date the Document

Further Resolved, that the Employer authorizes and directs its officers to take all necessary or appropriate actions to carry out the above resolutions, such as execution of an amended Service Agreement with Employee Benefits Corporation

X _____ 11/01/2013
Employer: Signature Date (mm-dd-yyyy)

David G. Anderson — Print Name

District Administrator — Title

