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97 JUN -9 PM 2:19

May 28, 1997

SPD
Pension and Welfare Benefits Administration
Room N-5644
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, D.C. 20210

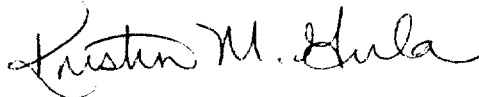
Plan Name: Tri-County Bank Cafeteria Plan
Plan Number: 511, 512, 513, respectively
EIN: 38-0377226

Dear Sirs:

I have enclosed the Summary Plan Description which outlines the provisions of the above-named Plan. We believe this meets your requirements, but please notify us should you require any additional information.

Very truly yours,

EMPLOYEE BENEFITS CONSULTING GROUP



Kristin M. Gula

/mhe

Enclosure

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TRI-COUNTY BANK

CAFETERIA PLAN

MEDICAL EXPENSE REIMBURSEMENT PLAN

DEPENDENT CARE ASSISTANCE PLAN

AND

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

<u>Article/ Section</u>	<u>Description</u>	<u>Page</u>
SUMMARY PLAN DESCRIPTION		-iv-
ARTICLE I INTRODUCTION		-1-
1.1 Cafeteria Plan Status		-1-
1.2 Medical Expense Reimbursement Plan Status		-1-
1.3 Dependent Care Assistance Plan Status		-1-
ARTICLE II ELIGIBILITY AND PARTICIPATION		-2-
2.1 Eligibility		-2-
2.2 Commencement of Participation		-2-
2.3 Cessation of Participation		-2-
ARTICLE III DEFINITIONS		-2-
3.1 "Benefits"		-2-
3.2 "Cancer Insurance Plan"		-2-
3.3 "Code"		-2-
3.4 "Dental Plan"		-2-
3.5 "Dependent"		-2-
3.6 "Dependent Care Assistance"		-3-
3.7 "Disability Plan"		-3-
3.8 "Earned Income"		-3-
3.9 "Educational Institution"		-3-
3.10 "Effective Date"		-3-
3.11 "Eligible Employment Related Expenses"		-3-
3.12 "Eligible Medical Care Expense"		-3-
3.13 "Employee"		-4-
3.14 "Full-Time Employee"		-4-
3.15 "Life Insurance Plan"		-4-
3.16 "Medical Care Expense"		-4-
3.17 "Medical Plan"		-4-
3.18 "Participant"		-4-
3.19 "Plan Administrator"		-4-
3.20 "Plan Year"		-4-
3.21 "Qualifying Day Care Center"		-4-
3.22 "Qualifying Individual"		-4-
3.23 "Qualifying Services"		-5-

<u>Article/ Section</u>	<u>Description</u>	<u>Page</u>
3.24	"Spouse"	-5-
3.25	"Student"	-5-
ARTICLE IV CAFETERIA PLAN BENEFITS		-5-
4.1	Benefit Options	-5-
4.2	New Participants	-7-
4.3	Increase in Cost of Benefits.	-7-
4.4	Coverages Provided Under Separate Plans	-7-
ARTICLE V ELECTION PROCEDURES		-7-
5.1	Election Form.	-7-
5.2	Election Procedure	-7-
5.3	Failure to Complete Election Form.	-8-
5.4	Change of Election by Plan Administrator	-8-
5.5	Change of Election by Participant	-8-
5.6	Election Period	-10-
ARTICLE VI MEDICAL EXPENSE REIMBURSEMENT PLAN BENEFITS		-10-
6.1	Description of Medical Care Expense Reimbursement Benefits	-10-
6.2	Electing Annual Amount of Medical Care Expense Reimbursement	-10-
6.3	Limitation on Benefits	-10-
6.4	Application for Reimbursement	-11-
6.5	Forfeiture of Unused Medical Expense Reimbursement Amount	-11-
ARTICLE VII DEPENDENT CARE ASSISTANCE PLAN BENEFITS		-11-
7.1	Description of Dependent Care Assistance Benefits	-11-
7.2	Electing Annual Amount of Dependent Care Reimbursement	-12-
7.3	Limitation on Benefits	-12-
7.4	Application for Reimbursement	-13-
7.5	Forfeiture of Unused Dependent Care Reimbursement Amount	-14-
7.6	Statement of Expenses	-14-
ARTICLE VIII ADMINISTRATION OF PLANS		-14-
8.1	Plan Administrator	-14-
8.2	Examination of Records	-15-
8.3	Reliance on Receipts, Etc.	-15-
8.4	Funding	-15-

<u>Article/ Section</u>	<u>Description</u>	<u>Page</u>
8.5	Information to be Furnished	-15-
8.6	Limitation of Rights	-15-
8.7	COBRA Rights	-15-
8.8	Nature of Benefits.	-16-
8.9	Non-Alienation	-16-
8.10	Severability	-16-
8.11	Gender	-16-
8.12	Governing Law	-16-
8.13	Employment Relationship	-16-
ARTICLE IX AMENDMENT AND TERMINATION OF PLANS		-16-
ARTICLE X CLAIMS PROCEDURE		-16-
10.1	Procedure for Claims of Employees	-16-
10.2	Statement of ERISA Rights	-17-

SUMMARY PLAN DESCRIPTION

NAME OF PLANS: Tri-County Bank Cafeteria Plan
Tri-County Bank Medical Expense Reimbursement Plan
Tri-County Bank Dependent Care Assistance Plan

NAME OF SPONSOR: Tri-County Bank, a Michigan corporation

ADDRESS OF SPONSOR: 4222 Main Street
Brown City, Michigan 48416

TELEPHONE NUMBER: (810) 346-2745

EMPLOYER ID NUMBER: 38-0377226

PLAN NUMBERS: 511, 512 and 513, respectively

TYPES OF PLANS: Cafeteria Plan, Medical Expense Reimbursement Plan and
Dependent Care Assistance Plan

PLAN YEAR: Begins January 1 and ends on December 31

**PLAN ADMINISTRATOR
AND AGENT FOR SERVICE
OF LEGAL PROCESS:** Norma Vinande

Benefits are provided through employee contributions and Company contributions.

A claims procedure and ERISA statement are stated at the end of the document.

This one document includes three separate plans: a Cafeteria Plan, a Medical Expense Reimbursement Plan and a Dependent Care Assistance Plan, and also constitutes the Summary Plan Description for each plan.

**TRI-COUNTY BANK
CAFETERIA PLAN
MEDICAL EXPENSE REIMBURSEMENT PLAN
DEPENDENT CARE ASSISTANCE PLAN**

The Board of Directors of Tri-County Bank, a Michigan corporation (the "Company"), has approved and adopts the Cafeteria Plan, Medical Expense Reimbursement Plan and Dependent Care Assistance Plan (collectively the "Plans") set forth in this document this 1st day of January, 1997.

WHEREAS, the Company wishes to adopt a Cafeteria Plan under §125 of the Code, a Medical Expense Reimbursement Plan under §105(b) of the Code, and a Dependent Care Assistance Plan under §129 of the Code, and allow its employees who satisfy the eligibility requirements set forth herein to participate in each Plan;

NOW, THEREFORE, the Company adopts the following Plans:

**ARTICLE I
INTRODUCTION**

1.1 Cafeteria Plan Status. This document is intended to constitute a written plan qualifying as a Cafeteria Plan under §125 of the Code. The purpose of this document as a Cafeteria Plan is to provide each Participant the choices described in Section 4.1 below. It is intended that the Participant's choices will not constitute "constructive receipt" of income to the Participant.

1.2 Medical Expense Reimbursement Plan Status. This document is also intended to constitute a separate written plan qualifying as a Medical Expense Reimbursement Plan within the meaning of §105(b) of the Code. The purpose of this document as a Medical Expense Reimbursement Plan is to reimburse Participants who elect this Benefit for Eligible Medical Care Expenses incurred by the Participant for the Participant and his/her Dependents. It is also intended that the reimbursements under the Medical Expense Reimbursement Plan be eligible for exclusion from the Participant's gross income under §105(b) of the Code.

1.3 Dependent Care Assistance Plan Status. This document is also intended to constitute a separate written plan qualifying as a Dependent Care Assistance Plan within the meaning of §129 of the Code. The purpose of this document as a Dependent Care Assistance Plan is to reimburse Participants who elect this Benefit for Eligible Employment Related Expenses incurred by the Participant. It is also intended that the reimbursements under the Dependent Care Assistance Plan be eligible for exclusion from the Participant's gross income under §129(a) of the Code.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.1 Eligibility. Each Full-Time Employee is eligible to participate in each of the Plans established hereunder after the completion of 90 days of employment with the Company as a Full-Time Employee.

2.2 Commencement of Participation. Each Full-Time Employee will commence participation in the Plans on the first day of the calendar month coincident with or following completion of his/her 90th day of employment with the Company as a Full-Time Employee. However, commencement of coverage and Benefits under the Medical Plan, Dental Plan, Cancer Insurance Plan, Disability Plan and Life Insurance Plan will be as stated in each such separate plan.

2.3 Cessation of Participation. A Participant will cease to be a Participant in each of the Plans established in this document as of the earlier of: (a) the date on which the Plan terminates, or (b) the date on which he/she ceases to be a Full-Time Employee; provided, however, a Participant may continue to participate in the Medical Expense Reimbursement Plan and the Dependent Care Assistance Plan until the end of the Plan Year, as specifically provided below in Sections 6.3 and 7.3, respectively.

ARTICLE III
DEFINITIONS

3.1 "Benefits" mean the amounts paid to, or coverage or compensation received by, Participants under the Plans established in this document, as reimbursement, compensation or coverage, whichever the Participant elects.

3.2 "Cancer Insurance Plan", for purposes of the Cafeteria Plan, means the group cancer insurance plan sponsored by the Company for its Employees, as more particularly described in the group insurance contract issued by the insurance company.

3.3 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section.

3.4 "Dental Plan", for purposes of the Cafeteria Plan, means the group dental plan sponsored by the Company, as more particularly described in the group insurance contract issued by the insurance company.

3.5 "Dependent", for purposes of the Medical Plan, Dental Plan, Life Insurance Plan and Cancer Insurance Plan has the same meaning as given such term under each such separate plan. For purposes of the Medical Expense Reimbursement Plan, "Dependent" means and includes a Participant's spouse and those individuals who qualify as a "dependent" for income tax

purposes under §152 of the Code. For purposes of the Dependent Care Assistance Plan, "Dependent" means and includes any individual who is (i) a "dependent" of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to a deduction under §151(c) of the Code, or (ii) a "dependent" (within the meaning of §152 of the Code) or the Spouse of the Participant who is physically or mentally incapable of caring for himself/herself. For purposes of determining whether an individual is a Dependent of the Participant under the Dependent Care Assistance Plan, the special rules of §21(e)(5) of the Code apply with respect to treating a child under the age of 13 as the dependent of the custodial parent in the case of divorced parents.

3.6 "Dependent Care Assistance", for purposes of the Dependent Care Assistance Plan, means the payment or provision of those services which, if paid for by the Participant, would be considered "employment-related expenses" under §21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment), and is determined in accordance with §129(e)(1) of the Code.

3.7 "Disability Plan", for purposes of the Cafeteria Plan, means the group long-term disability insurance plan sponsored by the Company for its Employees, as more particularly described in the group insurance contract issued by the insurance company.

3.8 "Earned Income", for purposes of the Dependent Care Assistance Plan, means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits), but such term does not include any amounts received: (i) under the Plans established hereunder or any other dependent care assistance program under §129 of the Code; (ii) as a pension or annuity; or (iii) as unemployment or workmen's compensation.

3.9 "Educational Institution", for purposes of the Dependent Care Assistance Plan, means any educational organization, the primary function of which is the presentation of formal instruction, and which normally maintains a regular faculty and curriculum, and normally has a regularly enrolled body of students at the place where its educational activities are regularly carried on.

3.10 "Effective Date", for all Plans established hereunder, is January 1, 1997.

3.11 "Eligible Employment Related Expenses", for purposes of the Dependent Care Assistance Plan, means all Employment Related Expenses incurred by a Participant which are paid to an individual who is not: (i) a Dependent of the Participant, or (ii) a child of the Participant under the age of 19.

3.12 "Eligible Medical Care Expense", for purposes of the Medical Expense Reimbursement Plan, means any Medical Care Expense which was not allowed as a deduction to the Participant under §213 of the Code for any prior calendar year, and which is paid to the Participant (directly or indirectly) as reimbursement for such expense incurred by the Participant for himself/herself and/or his/her Dependent.

3.13 "Employee" means any individual employed by the Company, but does not include independent contractors or leased employees.

3.14 "Full-Time Employee" means any Employee who is a member of the Board of Directors of the Company, and any Employee who is regularly scheduled to work at least 35 hours per work week.

3.15 "Life Insurance Plan", for purposes of the Cafeteria Plan, means the group life insurance plan sponsored by the Company for its Employees, as more particularly described in the group contract/policy issued by the insurance company.

3.16 "Medical Care Expense", for purposes of the Medical Expense Reimbursement Plan, has the same meaning as defined in §213(d) of the Code, and includes amounts paid for the diagnosis, cure, mitigation or prevention of disease, or for the purpose of affecting any structure or function of the body; and any amounts paid for transportation primarily for, and essential to, such medical care; but does not include certain cosmetic surgery or expenses for premium payments for certain other health coverage for the Participant's spouse or Dependents.

3.17 "Medical Plan", for purposes of the Cafeteria Plan, means the group medical/hospitalization plan sponsored by the Company for its Employees, as more particularly described in the group contract/policy issued by the insurance company.

3.18 "Participant" means any Full-Time Employee who is eligible to participate in the Plans set forth in this document in accordance with ARTICLE II.

3.19 "Plan Administrator" means the person(s) or committee as may be appointed from time to time by the President of the Company to supervise the administration of the Plans. The initial Plan Administrator is Norma Vinande.

3.20 "Plan Year", for all Plans established hereunder, means the 12-month period beginning on January 1 and ending on December 31.

3.21 "Qualifying Day Care Center", for purposes of the Dependent Care Assistance Plan, means a day care center which: (i) complies with all applicable laws and regulations of the State and town, city or village in which it is located; (ii) provides care for more than six individuals (other than individuals who reside at the day care center); and (iii) receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit).

3.22 "Qualifying Individual", for purposes of the Dependent Care Assistance Plan, means a Dependent of the Participant who is under the age of 13; or a Dependent of the Participant who is physically or mentally incapable of caring for himself/herself.

3.23 "Qualifying Services", for purposes of the Dependent Care Assistance Plan, means household services and services for the care of a Qualifying Individual which are performed (i) in the home of the Participant; or (ii) outside of the home of the Participant for (a) the care of a Dependent of the Participant under the age of 13, or (b) the care of any other Qualifying Individual who spends at least eight hours a day at the Participant's home. Qualifying Services do not include expenses incurred for services outside of the Participant's home at a camp where the Qualifying Individual stays overnight.

3.24 "Spouse", for purposes of the Dependent Care Assistance Plan, means the husband/wife of the Participant, subject to the special rules of §21(e)(3) and (4) of the Code. Thus, a spouse who is legally separated from the Participant under a decree of separate maintenance or legal separation is not considered "married".

3.25 "Student", for purposes of the Dependent Care Assistance Plan, means an individual who during each of five calendar months during a Plan Year is a full-time student at an Educational Institution.

ARTICLE IV CAFETERIA PLAN BENEFITS

4.1 Benefit Options. Each Plan Year, a Participant may elect to receive one or more of the Benefits described below:

A. Medical Plan Coverage. Each Participant may elect to receive coverage for himself/herself alone, or for himself/herself and his/her Dependents, under the Medical Plan for the Plan Year, and must agree to pay the Employee portion of the premium cost, if any, for the coverage so elected.

B. Dental Plan Coverage. Each Participant may elect to receive coverage for himself/herself alone, or for himself/herself and his/her Dependents, under the Dental Plan for the Plan Year, and must agree to pay the Employee portion of the premium cost, if any, for the coverage so elected.

C. Cash in Lieu of Medical Plan Coverage. Each Participant may elect to waive all coverage for himself/herself and his/her Dependents under the Medical Plan, and receive additional compensation in lieu thereof, in an amount specified on the Election Form for such Plan Year; provided, however, he/she must be covered under some other medical/hospitalization plan or policy and must provide proof, satisfactory to the Plan Administrator, of such other coverage, in order to waive coverage under the Medical Plan. The additional compensation will be paid on a semi-annual basis on June 1 and December 1.

D. Medical Plan Premium Conversion Option. Each Participant who receives coverage under the Medical Plan, and who is required to pay for a portion of the premium costs for such coverage, may elect to reduce his/her compensation (through payroll

reduction) and pay his/her portion of such premium cost with pre-taxed dollars. The amount of payroll reduction will automatically be adjusted to take into account any change in the premium cost for the Medical Plan coverage elected by such Participant that occurs during the Plan Year.

E. Dental Plan Premium Conversion Option. Each Participant who is entitled to coverage under the Dental Plan, and who is required to pay a portion of the premium cost for such coverage, may elect to reduce his/her compensation (through payroll deduction) and pay his/her portion of such premium cost with pre-tax dollars. The amount of payroll reduction will automatically be adjusted to take into account any change in the premium cost for Dental Plan coverage that occurs during the Plan Year.

F. Disability Plan Premium Conversion Option. Each Participant who is entitled to coverage under the Disability Plan, and who is required to pay a portion of the premium cost for such coverage, may elect to reduce his/her compensation (through payroll deduction) and pay his/her portion of such premium cost with pre-tax dollars. The amount of payroll reduction will automatically be adjusted to take into account any change in the premium cost for Disability Plan coverage that occurs during the Plan Year.

G. Life Insurance Plan Premium Conversion Option. Each Participant who is entitled to coverage under the Life Insurance Plan, and who is required to pay a portion of the premium cost for such coverage, may elect to reduce his/her compensation (through payroll deduction) and pay his/her portion of such premium cost with pre-tax dollars. The amount of payroll reduction will automatically be adjusted to take into account any change in the premium cost for Life Insurance Plan coverage that occurs during the Plan Year.

H. Cancer Insurance Plan Premium Conversion Option. Each Participant who is entitled to coverage under the Cancer Insurance Plan, and who is required to pay a portion of the premium cost for such coverage, may elect to reduce his/her compensation (through payroll deduction) and pay his/her portion of such premium cost with pre-tax dollars. The amount of payroll reduction will automatically be adjusted to take into account any change in the premium cost for Cancer Insurance Plan coverage that occurs during the Plan Year.

I. Medical Expense Reimbursement Plan. Each Participant may elect to reduce his/her compensation by a specified amount set forth on the Election Form, not to exceed \$2,500, and contribute this amount to the Medical Expense Reimbursement Plan, and become eligible to receive reimbursement thereunder for Eligible Medical Care Expenses incurred by such Participant for himself/herself and/or his/her Dependents during the Plan Year.

J. Dependent Care Assistance Plan. Each Participant may elect to reduce his/her compensation by a specified amount set forth in the Election Form, not to exceed \$5,000, and contribute this amount to the Dependent Care Assistance Plan, and become eligible to receive reimbursement thereunder for Eligible Employment Related Expenses incurred by the Participant during such Plan Year.

4.2 New Participants. Any Participant who commences participation other than on the first day of the Plan Year is entitled to Benefits, pro-rata, on a prospective basis only, during the remaining months in the Plan Year after his/her Election Form is filed with, and accepted by, the Plan Administrator.

4.3 Increase in Cost of Benefits. In the event the cost of dependent coverage under the Medical Plan or Dental Plan, or the cost of coverage for the Participant under the Cancer Insurance Plan, Disability Plan and/or Life Insurance Plan, increases during a Plan Year, each Participant who elected such coverage for such Plan Year must agree to make a corresponding increase in his/her salary reduction for such Plan Year for such coverage. In such event, the Company will automatically reduce such Participant's compensation (through payroll reduction) to pay for the increased premium cost for such Plan Year. Notwithstanding the foregoing, to the extent permitted under §125 of the Code, if such increase in the premium cost for such Plan Year is "substantial" (as determined under the Income Tax Regulations under §125 of the Code), and if the Company offers other Medical Plan choices, the Participant may change his/her election and make a prospective new election to receive coverage under another group plan with similar coverage for the remainder of the Plan Year. In the event the cost of single coverage for the Participant under the Medical Plan or Dental Plan, or the cost of coverage for the Participant under the Disability Plan and/or Life Insurance Plan, which is paid for by the Company, increases during a Plan Year, the Company will pay for such increase for the cost of such coverage.

4.4 Coverages Provided Under Separate Plans. Coverage and Benefits under the Medical Plan, Dental Plan, Cancer Insurance Plan, Disability Plan and Life Insurance Plan are provided under the separate group contract(s)/plan(s) sponsored by the Company, and not under this Cafeteria Plan. The type and amount of Benefits available under the Medical Plan and Dental Plan (including deductibles and co-pays), and the eligibility and coverage requirements under all such plans (including pre-existing illness rules, coverage limits and coordination of benefit rules) are as provided under such separate contract(s)/plan(s). Similarly, if a Participant elects to make a contribution to the Medical Expense Reimbursement Plan and/or to the Dependent Care Assistance Plan, his/her eligibility for reimbursement/coverage will be provided under such respective Plans, and not under this Cafeteria Plan.

ARTICLE V

ELECTION PROCEDURES

5.1 Election Form. Each Plan Year each Participant will be required to complete and deliver to the Plan Administrator an Election Form, which will set forth the Participant's elections and the amount that the Participant is agreeing to reduce his/her compensation by in order to receive the coverage/Benefits he/she is electing for such Plan Year.

5.2 Election Procedure. To be effective as of the first day of the Plan Year, or the first day he/she becomes eligible in the case of a new Participant, each Election Form must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator

specifies, which date will be no later than the beginning of the Plan Year or the effective date of participation in the case of a new Participant.

5.3 Failure to Complete Election Form. Any Participant who fails to complete an Election Form for any Plan Year in a timely manner is deemed to have elected the same coverage under the Medical Plan, Dental Plan, Disability Plan, Life Insurance Plan and Cancer Insurance Plan as for the preceding Plan Year (in the order of priority listed). In addition, such Participant is deemed to have elected to receive his/her full, regular compensation in lieu of reducing his/her compensation, and is deemed to have chosen not to contribute to the Medical Expense Reimbursement Plan and/or the Dependent Care Assistance Plan for such Plan Year.

5.4 Change of Election by Plan Administrator. If the Plan Administrator determines, at any time during the Plan Year, that any Plan may fail to satisfy any nondiscrimination rule imposed by the Code or any limitation on Benefits provided to certain Employees, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation.

5.5 Change of Election by Participant. A Participant's election (or failure to elect) is irrevocable by the Participant during the Plan Year, subject to the following exceptions:

A. Change in Family Status. A Participant may revoke his/her election for the balance of a Plan Year and file a new Election Form only if both the revocation and the new election are on account of, and consistent with, a "change in family status". A "change in family status" for this purpose has the same meaning as given such term in the Income Tax Regulations under §125 of the Code, and, generally, includes the marriage or divorce of the Participant, the death of a spouse or other Dependent, the birth or adoption of a child, the termination or commencement of employment of a spouse, the switching from part-time to full-time employment, or vice versa, of the Participant or his/her spouse, the taking of an unpaid leave of absence of the Participant or his/her spouse, and such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under the Income Tax Regulations and rulings of the Internal Revenue Service. Any new election under this Section will be effective at such time as the Plan Administrator prescribes, in accordance with applicable rules of the Internal Revenue Service.

B. Family and Medical Leave Act (FMLA) Changes. A Participant may revoke his/her election for the balance of a Plan Year, if the Participant is on an unpaid leave of absence under the Family and Medical Leave Act ("FMLA"). A Participant who is returning from an unpaid FMLA leave is entitled to be reinstated in the group health plan(s) (i.e., Medical and Dental Plans) and in the Medical Expense Reimbursement Plan, if such Participant's group health plan coverage and/or participation in the Medical Expense Reimbursement Plan terminated while such Participant was on an unpaid FMLA leave (either by revocation or non-payment of premiums/contributions). Such Participant is entitled to be reinstated on the same terms as prior to taking the unpaid FMLA leave (including family or dependent coverage). However, such a Participant will have no greater rights to benefits for the remainder of the Plan Year than a Participant who has been continuously working during the Plan Year, as provided in the Income Tax Regulations

under §125 of the Code. The following additional rules apply to a Participant who is on an unpaid FMLA leave:

(1) A Participant who was making premium payments or contributions under the Cafeteria Plan or Medical Expense Reimbursement Plan, who chooses to continue the group health plan coverage(s) and/or his/her participation in the Medical Expense Reimbursement Plan while on the unpaid FMLA leave, is required to continue to pay/make his/her share of the premium payments/contributions for such continued coverage/participation, in the same amount as he/she was paying/making prior to the unpaid FMLA leave. Thus, a Participant who elected to reduce his/her compensation to purchase these benefits must continue on such program. In the event such a Participant elects to continue group health plan coverage and/or participation in the Medical Expense Reimbursement Plan, and continues to pay his/her portion of the premium for such coverage and make his/her contribution under the Medical Expense Reimbursement Plan, the Company will continue to make the same contribution to the cost of such coverage/participation as it was making prior to the unpaid FMLA leave. The Participant may either pre-pay his/her premium amount/contributions for the remainder of the calendar year in which the unpaid FMLA leave commences, or may continue to pay/make such premium amounts/contributions on the same periodic basis as existed prior to the unpaid FMLA leave. However, no premium amount/contributions may be pre-paid beyond the end of the calendar year in which the pre-payment is made.

(2) Unless otherwise required by law the group health coverage and participation in the Medical Expense Reimbursement Plan will cease upon failure of the Participant to make the required premium payments/contributions while on the unpaid FMLA leave.

(3) If a Participant's participation under the Medical Expense Reimbursement Plan terminates while the Participant is on an unpaid FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the participation is terminated. If the Participant subsequently elects to be reinstated in the Medical Expense Reimbursement Plan upon return from the unpaid FMLA leave for the remainder of the Plan Year, the Participant may not retroactively elect participation for claims incurred during the period when the participation was terminated. In addition, in the case of a Participant whose participation in the Medical Expense Reimbursement Plan terminated during an unpaid FMLA leave, which participation is reinstated for the remainder of the Plan Year upon return from the unpaid FMLA leave, the Participant's annual Medical Expense Reimbursement Limitation for such Plan Year will be prorated for the period during the unpaid FMLA leave for which no contributions were paid, and reduced by prior reimbursements.

(4) A Participant who returns from an unpaid FMLA leave may make a new election for the remainder of the Plan Year, if such return from leave without pay constitutes a change of family status under paragraph A. above.

(5) These rules do not apply to a Participant who is on a paid FMLA leave.

C. **Significant Cost or Coverage Changes.** A Participant who has chosen to purchase a particular type of group insurance coverage under Section 4.2 may revoke his/her election

for the balance of the Plan Year, and make new election which is both on account of and consistent with such revocation, if a significant increase in the cost or type of such coverage occurs with respect to such group insurance plan during the Plan Year. The interpretation of this paragraph will be made in a manner that is consistent with the Income Tax Regulations under §125 of the Code.

5.6 Election Period. The "Election Period" for all Benefits under all Plans established in this document is the Plan Year.

ARTICLE VI

MEDICAL EXPENSE REIMBURSEMENT PLAN BENEFITS

6.1 Description of Medical Care Expense Reimbursement Benefits. Each Participant who elects to reduce his/her compensation under the Cafeteria Plan and make a contribution to the Medical Expense Reimbursement Plan is eligible to receive reimbursement for Eligible Medical Care Expenses incurred by the Participant during the applicable Plan Year for himself/herself and/or his/her Dependent(s); provided, however, the total reimbursements paid to a Participant for expenses incurred in a single Plan Year may not exceed the lesser of: (i) the Participant's elected Annual Medical Expense Reimbursement Amount (described in Section 6.2 below) for such Plan Year, or (ii) the Annual Medical Expense Reimbursement Limitation (described in Section 6.3 below) for such Plan Year. The Participant's elected Annual Medical Expense Reimbursement Amount for any Plan Year will be allocated to an account (referred to as the Participant's "Medical Expense Reimbursement Account") for his/her benefit during such Plan Year under the Medical Expense Reimbursement Plan.

6.2 Electing Annual Amount of Medical Care Expense Reimbursement. A Participant who elects to reduce his/her compensation under the Cafeteria Plan and make a contribution to the Medical Expense Reimbursement Plan and become eligible for reimbursement for Eligible Medical Care Expenses incurred during such Plan Year must: (1) specify the maximum amount of reimbursement for which he/she is applying for such Plan Year prior to the commencement of the Plan Year (pursuant to ARTICLE V), to be indicated on the Cafeteria Plan Election Form as a total amount for the entire Plan Year (referred to as the Participant's "Annual Medical Care Expense Amount"), and (2) agree to have his/her compensation for such Plan Year reduced by such amount.

6.3 Limitation on Benefits. The maximum contribution which any Participant may make to the Medical Expense Reimbursement Account, and the maximum reimbursement for which any Participant will be eligible, may apply for any Plan Year is \$2,500. This amount is referred to as the "Annual Medical Expense Reimbursement Limitation". In addition, each Participant is entitled to reimbursement only for Eligible Medical Care Expenses incurred during the applicable Plan Year, and incurred during the period that he/she is a Participant under the Medical Expense Reimbursement Plan. If a Participant becomes ineligible to participate in the Plan or ceases to be a Full-Time Employee, such Participant may continue to be eligible for reimbursement of Eligible Medical Care Expenses incurred after the date he/she becomes ineligible or ceases to be a Full-Time Employee until the end of the Plan Year, but only to the

extent of the then remaining balance of the Annual Medical Expense Reimbursement Amount actually deducted from such Participant's compensation and allocated to his/her Medical Expense Reimbursement Account. In addition, such Participant may elect to have the balance of his/her elected Annual Medical Expense Reimbursement Amount for such Plan Year which has not already been contributed to the Plan deducted from his/her final paycheck, and continue to be eligible for reimbursement of Eligible Medical Care Expenses incurred after the date he/she becomes ineligible or ceases to be a Full-Time Employee, until the end of said Plan Year, to the maximum amount of reimbursement for which such Participant applied for such Plan Year. Any unused (unreimbursed) portion of such Participant's Medical Expense Reimbursement Account for each Plan Year will be forfeited as provided in Section 6.5 below.

6.4 Application for Reimbursement. In order to be entitled to Benefits under the Medical Expense Reimbursement Plan, the Participant must deliver, or cause to be delivered, to the Plan Administrator reasonable proof, satisfactory to the Plan Administrator, of the incurrence of the Eligible Medical Care Expenses during the applicable Plan Year. In addition, a properly completed Request for Reimbursement Form, with the proper invoices/receipts attached thereto, must be signed by the Participant and submitted to the Plan Administrator in order for the Participant to be entitled to a reimbursement. Reimbursements will be paid no later than the end of the calendar month following the month in which the Reimbursement Form is properly submitted to the Plan Administrator. Any Request for Reimbursement Form relating to expenses incurred in a Plan Year must be received by the Plan Administrator within 60 days following the close of such Plan Year, or the Participant's termination of participation in the case of the Plan Year in which such Participant's employment terminates, unless the Participant elects to continue his/her participation through the end of the Plan Year, as provided above.

6.5 Forfeiture of Unused Medical Expense Reimbursement Amount. Upon the completion of each Plan Year, the total unused (unreimbursed) portion of each Participant's Medical Expense Reimbursement Account will be forfeited (lost) by the Participant; and the Company, in its sole discretion, may use such forfeited amounts to help defray the expense of administering the Plans, or apply such amounts to reduce the cost of participation in the Plans for all Participants for any subsequent Plan Year, or for any other purpose.

ARTICLE VII

DEPENDENT CARE ASSISTANCE PLAN BENEFITS

7.1 Description of Dependent Care Assistance Benefits. Each Participant who elects to reduce his/her compensation under the Cafeteria Plan and make a contribution to the Dependent Care Assistance Plan is eligible to receive reimbursement for the Eligible Employment Related Expenses incurred by such Participant or such Participant's Spouse during the applicable Plan Year; provided, however, the total reimbursements made to any Participant for expenses incurred in a single Plan Year may not exceed the lesser of: (i) the Participant's elected Annual Dependent Care Assistance Amount (described in Section 7.2 below) for such Plan Year, or (ii) the Annual Dependent Care Assistance Limitation (described in Section 7.3 below) for such Plan Year. The Participant's elected Annual Dependent Care Assistance Amount for any Plan Year will be

allocated to an account (referred to as the Participant's "Dependent Care Assistance Account") for his/her benefit during such Plan Year under the Dependent Care Assistance Plan.

7.2 Electing Annual Amount of Dependent Care Reimbursement. A Participant who elects to reduce his/her compensation under the Cafeteria Plan and make a contribution to the Dependent Care Assistance Plan and become eligible for reimbursement for Eligible Employment Related Expenses incurred during such Plan Year must: (1) specify the maximum amount of reimbursement for which he/she is applying for such Plan Year prior to the commencement of the Plan Year (pursuant to ARTICLE V), to be indicated on the Cafeteria Plan Election Form as a total amount for the entire Plan Year (referred to as the Participant's "Annual Dependent Care Assistance Amount"), and (2) agree to have his/her compensation for such Plan Year reduced by such amount.

7.3 Limitation on Benefits.

A. Each Participant is entitled to reimbursement only for Eligible Employment Related Expenses incurred during the applicable Plan Year and incurred during the period that he/she is a Participant in the Dependent Care Assistance Plan. If a Participant becomes ineligible to participate in the Plan or ceases to be a Full-Time Employee, such Participant will have the choice to either (1) continue to be eligible for reimbursement of Eligible Employment Related Expenses incurred after the date he/she becomes ineligible or ceases to be a Full-Time Employee to the extent of the then remaining balance of his/her Dependent Care Assistance Account under the Dependent Care Assistance Plan until the end of the Plan Year, or (2) have the balance of his/her elected Annual Dependent Care Assistance Amount for such Plan Year which has not been contributed to the Plan deducted from his/her final paycheck, and continue to be eligible for reimbursement of Eligible Employment Related Expenses incurred after the date he/she becomes ineligible or ceases to be a Full-Time Employee, to the maximum amount of reimbursement for which such Participant applied for such Plan Year. Any unused (unreimbursed) portion of such Participant's Dependent Care Assistance Account for each Plan Year will be forfeited as provided in Section 7.5 below.

B. A Participant who is not married as of December 31 of any calendar year may not receive reimbursement for Eligible Employment Related Expenses incurred by him/her for such calendar year in excess of his/her Earned Income for such calendar year. A Participant who is married as of December 31 of any calendar year may not receive reimbursement for Eligible Employment Related Expenses incurred by him/her for such calendar year in excess of the lesser of: (i) the Participant's Earned Income for such calendar year; or (ii) the Earned Income of such Participant's Spouse for such calendar year. In addition, no Participant may receive more than (i) his/her elected Annual Dependent Care Assistance Amount for any Plan Year, or (ii) the amount excludable with respect to such Participant under §129(a) of the Code for any calendar year. In general, this excludable amount is \$5,000 (\$2,500 for a married Participant filing a separate return) for the calendar year. The limitation described in this Section is referred to as the "Annual Dependent Care Assistance Limitation".

C. For purposes of the foregoing limitations, a Spouse of a Participant who is not employed during the calendar year in which the Participant incurs Eligible Employment Related Expenses, and which Spouse is either incapacitated or a Student, is deemed to have Earned Income for each month during which such Spouse is either incapacitated or a Student of: (i) \$200, if there is one Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses; or (ii) \$400, if there is more than one Qualifying Individual for whom the Participant incurs Eligible Employment Related Expenses.

7.4 Application for Reimbursement. In order to be entitled to Benefits under the Dependent Care Assistance Plan, the Participant must deliver, or cause to be delivered, to the Plan Administrator reasonable proof, satisfactory to the Plan Administrator, of the incurrence of the Eligible Employment Related Expenses for a Qualifying Individual during the applicable Plan Year. Each Participant who desires to receive Benefits for Eligible Employment Related Expenses incurred for Qualifying Services must submit to the Plan Administrator a statement containing the following information:

- A. The Qualifying Individual(s) for whom the Qualifying Services were performed;
- B. The nature of the Qualifying Services performed for which the Participant seeks reimbursement or payment;
- C. The relationship, if any, of the person performing the Qualifying Services for the Participant;
- D. If the Qualifying Services were performed by a Dependent of the Participant, the age of the Dependent;
- E. A statement as to where the Qualifying Services were performed;
- F. If any of the Qualifying Services were performed outside of the Participant's home, a statement as to whether the Qualifying Individual for whom such Qualifying Services were performed spends at least eight hours a day in the Participant's home;
- G. If the Qualifying Services were performed in a day care center, a statement that: (i) the day care center complies with all applicable laws of the State of Michigan and the town, city or village in which it is located; (ii) the day care center provides care for more than six individuals (other than individuals residing at the center); and (iii) the amount of the fee paid to the center; and
- H. If the Participant is married and the Participant's Spouse is unemployed, a statement that the Spouse is either incapacitated or a full-time Student attending an Educational Institution, and the months during the year in which said Spouse will attend such Educational Institution.

In addition, a properly completed Request for Reimbursement Form, with the additional information identified above attached thereto, must be completed and signed by the Participant, and submitted to the Plan Administrator, in order for the Participant to be entitled to a reimbursement. Reimbursements will be paid no later than the end of the calendar month following the month in which the Reimbursement Form is properly submitted to the Plan Administrator. Any Request for Reimbursement Form relating to expenses incurred in a Plan Year must be received by the Plan Administrator within 60 days following the close of such Plan Year or the Participant's termination of participation in the case of the Plan Year in which such Participant's employment terminates, unless the Participant elects to continue his/her contributions and participation through the end of the Plan Year.

7.5 Forfeiture of Unused Dependent Care Reimbursement Amount. Upon the completion of each Plan Year, the total unused (unreimbursed) portion of each Participant's Dependent Care Assistance Account will be forfeited (lost) by the Participant; and the Company, in its sole discretion, may use such forfeited amounts to help defray the expense of administering the Plans established hereunder, or apply such amounts to reduce the cost of participation in the Plans for all Participants for any subsequent Plan Year, or for any other purpose.

7.6 Statement of Expenses. On or before January 31 of each calendar year, the Plan Administrator will furnish to each Participant a written statement showing the amounts paid, or expenses incurred by the Dependent Care Assistance Plan in providing Eligible Employment Related Expenses to such Participant during the previous calendar year.

ARTICLE VIII ADMINISTRATION OF PLANS

8.1 Plan Administrator. The administration of the Plans established in this document is under the supervision of the Plan Administrator. The President of the Company has the right to appoint and remove the Plan Administrator at any time. It is a duty of the Plan Administrator to see that the Plans are carried out, in accordance with their terms, without discrimination. The Plan Administrator has the full power to administer the Plans, subject to any applicable requirements of law and a Participant's rights to a review and appeal as set forth in ARTICLE X. For this purpose, the Plan Administrator's powers includes, but is not limited to, the following authority, in addition to all other powers provided in this document:

- A.** To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plans;
- B.** To interpret the Plans, the Plan Administrator's interpretation to be final and conclusive on all persons claiming reimbursement or Benefits under any Plan;
- C.** To decide all questions concerning any Plan and the eligibility of any person to participate in any Plan and his/her commencement and termination of participation dates;

D. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering any Plan; and

E. To allocate and delegate the Plan Administrator's responsibilities under any Plan, and to designate other persons to carry out any of the Plan Administrator's responsibilities under any Plan, any such allocation, delegation or designation to be in writing.

Any decisions to be made with respect to the eligibility, entitlement, payment or reimbursement of Benefits to, or for the benefit of, the acting Plan Administrator will be made or ratified by an authorized officer of the Company who is not the Plan Administrator.

8.2 Examination of Records. The Plan Administrator will make available to each Participant such records under any Plan established in this document as pertain to him/her, for examination at reasonable times during normal business hours.

8.3 Reliance on Receipts, Etc. In administering any Plan, the Plan Administrator is entitled, to the extent permitted by law, to rely conclusively on all receipts, papers, statements, certificates, opinions and reports which are made or furnished by any Employee, Participant, accountant, counsel or other agent employed or engaged by the Plan Administrator.

8.4 Funding. The coverage under the Cafeteria Plan is funded in part by Employee contributions and in part by Company contributions. The Medical Expense Reimbursement Plan and Dependant Care Assistance Plan are funded solely through Employee contributions (through payroll deductions).

8.5 Information to be Furnished. Participants must provide the Company and the Plan Administrator with such information, and must sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plans.

8.6 Limitation of Rights. Neither the establishment of any Plan nor any amendment thereof, nor the payment of any Benefits, is to be construed as giving to any Participant or other person any legal or equitable right against the Company or the Plan Administrator, except as specifically provided herein. In the event that the Company fails to obtain coverage for any Participant or Dependent under any separate insurance plan, as elected by the Participant, the Company is only liable for the premium cost that it would have paid for the months that such coverage should have been in force, and is not liable for the cost of any Benefit that would have been received had the coverage been in force.

8.7 COBRA Rights. Nothing in any Plan is deemed to affect a Participant's or Dependent's rights, if any, under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended, for continuation coverage under the Company's "health care plans" as that term is defined in §5000(b)(1) of the Code for purposes of §4980B of the Code. However, COBRA continuation rights do not include the right to continued participation in any of the Plans established under this document.

8.8 Nature of Benefits. The Benefits provided hereunder are in the form of compensation to the Participant in return for services rendered, or to be rendered, by the Participant to the Company.

8.9 Non-Alienation. No Benefit may in any manner be alienated, sold, transferred, assigned, pledged or subjected to attachment, garnishment or encumbrance of any kind.

8.10 Severability. The invalidity of any provision of this document does not invalidate the remainder hereof.

8.11 Gender. As used herein, the masculine includes the feminine and neuter, and the singular, the plural, and vice versa, whenever such meanings would be appropriate.

8.12 Governing Law. This document, the Plan and any matter relating hereto, are governed by, and are to be interpreted in accordance with, the laws of the State of Michigan, except as specifically pre-empted by, and governed by, the Employees Retirement Income Security Act of 1974, as amended ("ERISA").

8.13 Employment Relationship. Nothing in this document is to be construed to create, continue or modify the employment relationship of any Employee.

ARTICLE IX **AMENDMENT AND TERMINATION OF PLANS**

Notwithstanding anything herein to the contrary, the Company reserves the right to alter, amend, terminate or revoke any Plan or Benefit established by this document, at any time and from time to time, and to change the provider of any coverage under the Medical Plan and/or Dental Plan, Disability Plan and/or Life Insurance Plan, and no Employee, Participant, Dependent or any other person (whether or not then absent from work because of illness, personal injury, disability or sickness, and whether or not then under medical, dental, psychiatric, surgical or hospital treatment or care) will have any further right, title, interest or claim, legal or equitable, in or to any reimbursement or Benefit payable under such Plan beyond the Plan Year in which such Plan or Benefit is terminated.

ARTICLE X **CLAIMS PROCEDURE**

10.1 Procedure for Claims of Employees. Upon the receipt of a copy of this document or an Election Form from the Company or upon the initial receipt of reimbursement or Benefits under any Plan which, in the opinion of the Participant, is of a different amount, or paid pursuant to a method different, than what the Participant believes he/she is entitled to:

A. The Participant may make a formal written claim for Benefits to the Plan Administrator explaining in detail the reasons for the claim. Within 90 days from the receipt of

the Participant's claim for Benefits, the Plan Administrator must, by written response, inform the Participant of a decision to allow or disallow, in whole or in part, such claim for Benefits, attaching thereto the detailed reason(s) for such decision and the rules for requesting a review. In a special case, the Plan Administrator may take up to an additional 90 days to decide; provided that notice is given to the Participant explaining why more time is needed.

B. In the event the Plan Administrator's decision is to disallow, in whole or in part, the Participant's claim for Benefits, the Participant has the right, within 60 days from the receipt of the Plan Administrator's decision, to request a review of such decision. As part of the review, the Participant is allowed to see all Plan documents and other papers which affect his/her claim, and is allowed to have a representative present at the review. If a claim is denied because the Plan Administrator needs more information to make a decision, the Plan Administrator must notify the Participant of the additional information needed.

C. Within 60 days after the request for review is filed with the Plan Administrator, the review must be conducted and a decision rendered. The review may be conducted by the Plan Administrator or any other person or persons designated by the Company, and such reviewing person(s) has the authority to make a final decision on the claim. In a special case, the person(s) conducting the review may take up to an additional 60 days to render a decision; provided that notice is given to the Participant explaining why more time is needed.

10.2 Statement of ERISA Rights. Each Participant in each Plan is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). Under the provisions of ERISA, an employer is required to notify all plan participants of the following rights:

"To examine, without charge, at the Plan Administrator's office all plan documents.


To obtain copies of all plan documents and other plan information upon written request of the Plan Administrator. The Plan Administrator may charge a reasonable fee for copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the welfare benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan reviewed and your claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or

in part, you may file a suit in a state or federal court. If it should happen that you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor."

IN WITNESS WHEREOF, the Company has caused this document to be executed by an authorized officer as of the day and year first above written.

TRI-COUNTY BANK
a Michigan corporation

By: 

Its: Exec. Vice President

F:TRI-COUNTY-CAP.PLN
MKM:12/30/96:D