Exhibit F-2
3 pages

AMENDMENT RESOLUTION*
-of the-
PLAN ADMINISTRATOR
-for-
Squaw Valley Public Service District
RESOLUTION 2017-19

The undersigned, being the Plan Administrator of Squaw Valley Public Service District (the "Corporation"), a California Corporation, do hereby consent to the following resolutions without a meeting:

WHEREAS, effective September 1, 1997, Squaw Valley Public Service District ("Corporation") adopted the Squaw Valley Public Service District Flexible Benefit Plan ("Plan") for the benefit of its employees; and

WHEREAS, pursuant to Section 8.1 of the Plan, the Corporation may amend the Plan at any time by an instrument in writing.

NOW THEREFORE, BE IT RESOLVED, that the Plan is hereby amended and restated effective 01/01/2018 as an employee welfare benefit plan to be maintained by the Corporation pursuant to Section 125 of the Internal Revenue Code, and that a copy of the plan document, as amended and restated, be attached to these resolutions; and be it further

RESOLVED, that the proper officers of the corporation are authorized to execute the amended and restated Plan, to receive employee contributions and pay benefits as provided therein, and to do every other act or thing necessary or proper to meet and comply with the obligations of the Corporation as therein provided and to carry these resolutions into full force and effect, and to direct counsel to take such action as may be necessary to satisfy any applicable requirements of law.

IN WITNESS WHEREOF, this consent has been executed on this 28th day of November, 20 17.

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(Plan Administrator)

**Effective January 1, 2018; Plan is hereby amended to increase the Medical Maximum to $2,650.*

FLEXIBLE BENEFIT PLAN
with Beniversal® MasterCard®
*PLAN HIGHLIGHTS**

A. General Plan Information

1. Employer name: Squaw Valley Public Service District.
2. Plan name: Squaw Valley Public Service District Flexible Benefit Plan.
3. Plan type: The Plan is a welfare plan designed to provide benefits permitted under Section 125 of the Internal Revenue Code (IRC). The Plan name and Plan number should be used in any formal correspondence relating to the Plan.
4. Eligibility requirements: Must be an employee of Squaw Valley Public Service District who has satisfied the eligibility conditions for the Employer's Group Medical Plan.
   - *If you or your spouse is reporting contributions to a Health Savings Account (HSA), you are not eligible for a Medical FSA.*
5. The effective date on which you can begin participating in the Plan: On the first of the month once the eligibility requirements have been met.
6. Kinds of group insurance for which you can pay your share of premiums through the Plan: Medical, Dental, Vision, Group Term Life and AD&D Insurances.
7. The Plan Year begins on January 1 and ends on December 31. The Annual Election Period begins on October 23 and ends on November 21.
8. Plan effective date: September 1, 1997.
9. Plan number: 501.
10. Employer ID number: 94-1636514.
11. Name, address and telephone number of the Plan Administrator:
    Squaw Valley Public Service District
    305 Squaw Valley Road
    PO Box 2026
    Olympic Valley, CA 96146
    (530) 583-4692
12. Agent for service of process: Squaw Valley Public Service District.
13. The use of the term "you" throughout the Plan Highlights refers to the Participant.
14. Insurance Control Clause. In the event of a conflict between the terms of the Plan and the terms of an insurance contract of an independent third party insurer whose product is being used in conjunction with the Plan, the terms of the insurance contract shall control matters related to the insurance contract, such as defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.
15. Employer's Protective Clauses. Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim. The Employer shall not be responsible for the validity of any insurance contract issued in connection with the Plan or for the failure on the part of an insurer to make payments provided for under any insurance contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer.
16. No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

B. Flexible Spending Accounts (FSAs)

1. Types of FSAs

Medical FSA

(a) Maximum amount you can set aside per Plan Year for reimbursement of eligible medical expenses as defined by IRC Section 213(d) except for insurance premiums: $2,650.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan,

- during the Plan Year and
- prior to the date on which you become ineligible.

- The Beniversal Card may no longer be used to access Medical FSA funds. You may submit a claim for reimbursement of eligible expenses.

Dependent Care FSA

(a) Maximum amount you can set aside per calendar year for reimbursement of eligible dependent care services, as defined by IRC Section 21(b), is limited to the smallest of the following amounts:
- $5,000 if single or if married and filing jointly; $2,500 if married and filing separately.
- The earned income of the participant.
- The earned income of the participant's spouse.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year or the 2 ½ month grace period following the end of the Plan Year. The grace period ends March 15.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year in which you become ineligible.

2. Claims for FSAs

Claim submission time frames for Medical FSA

(a) Claims must be received by Benefit Resource, Inc. before the end of the 90 day run-out after the Plan Year ends.
(b) Claims denied during the run-out may be resubmitted, but must be received by Benefit Resource within 21 days after the run-out ends.
(c) Eligible participant are allowed to rollover up to $500 of unused Medical FSA funds to the next Plan Year after the end of the time frame in (b) is completed for the current Plan Year. The minimum amount that can rollover must be greater than $10.
(d) Any funds remaining in your Medical FSA after this will be forfeited.

Claim submission time frames for Dependent Care FSA

(a) Claims must be received by Benefit Resource, Inc. before the end of the one-month run-out that follows the grace period. The run-out ends April 15.
(b) Claims denied during the run-out may be resubmitted, but must be received by Benefit Resource no later than May 15.
(c) Any funds remaining in your Dependent Care FSA after this will be forfeited.

Claim reimbursements

(a) Complete your claim following all instructions.
(b) You must indicate on your claim form if you wish to have a grace period expense reimbursed from prior Plan Year funds for Dependent Care FSA.
(c) Your completed claim form and the required documentation must be received by Benefit Resource at least 5 business days prior to the processing day.
(d) Claim reimbursements are processed daily.
(e) There is a minimum reimbursement amount of $15 (except during the run-out after the end of the Plan Year).
(f) A claim should never be submitted for an expense that has been paid for with a Beniversal Card or reimbursed from any other source.

3. Beniversal Card for Medical FSA

(a) The Beniversal Card allows you to access Medical FSA funds to pay for eligible medical services at qualified merchants.
(b) The card may only be used to pay for eligible medical services after they have been provided. The IRS allows one exception: eligibility of orthodontia expenses can be based on either date of payment, date of service or payment due date on coupons/statements.
(c) Payment of a current Plan Year medical service with the card must be completed before the Plan Year ends.
(d) Once a new Plan Year begins, only Medical FSA funds associated with the new Plan Year will be available on the card. To access any remaining balance from the prior Plan Year Dependent Care FSA account, submit a claim requesting reimbursement *(refer to Section B. 2)*.
(e) You are advised to save all documentation related to medical expenses paid with your card, as IRS regulations require all FSA transactions to be verified for eligibility.
(f) If a card transaction cannot be automatically verified, you will be contacted to submit documentation for that transaction.
(g) Medical expenses paid with the card should never be submitted for claim reimbursement.