THIS DOCUMENT IS AN AMENDED AND RESTATED

SUMMARY PLAN DESCRIPTION

FOR THE

JACKSON PUBLIC SCHOOLS

FLEXIBLE SPENDING PLAN

Effective Date of Amended and Restated Flexible Spending Plan

October 1, 2017

Group Number: G-766

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INTRODUCTION

This booklet is a summary of the provisions of the Plan. While every effort has been made to have these materials be as complete and accurate as possible, the Summary Plan Description cannot be a full restatement of the Plan. If there is any conflict between this Summary Plan Description and the actual terms of the Plan, the provisions of the Plan will control.

JACKSON PUBLIC SCHOOLS
FLEXIBLE SPENDING PLAN

GENERAL INFORMATION

EMPLOYER, PLAN SPONSOR, AND PLAN ADMINISTRATOR

Jackson Public Schools
522 Wildwood Avenue
Jackson, Michigan 49201
(517) 841-2200

EMPLOYER IDENTIFICATION NUMBER

38-6001907

TYPE OF PLAN

Section 125 (Flexible Spending) Plan:

- Pre-Tax Premium Payment Program
- Medical Reimbursement Program
- Dependent Care Reimbursement Program
- Health Savings Account Program

CLAIM ADMINISTRATOR

ASR Health Benefits
P.O. Box 6392
Grand Rapids, Michigan 49516-6392
(616) 957-1751 or (800) 968-2449

PLAN YEAR

October 1 – September 30

SERVICE OF LEGAL PROCESS

Service of legal process may be made upon the Plan Administrator or upon the following individual:

Deputy Superintendent for Finance and Operations
Jackson Public Schools
522 Wildwood Avenue
Jackson, Michigan 49201

HOW THE PLAN OPERATES

The **Jackson Public Schools Flexible Spending Plan** is a benefit program by which you may do the following: (a) elect coverage under the Employer's group health plan and certain other insurance programs offered by the Employer and pay your required contributions with pre-tax dollars, or waive coverage and receive your full pay plus an additional amount, as determined by the Employer; (b) pay certain uninsured medical expenses with pre-tax dollars; (c) pay certain dependent care expenses with pre-tax dollars; and (d) contribute to your health savings account (HSA) with pre-tax dollars.

Under the Plan, you may request that the Employer withhold a portion of your compensation to purchase qualifying benefits during the year. You will not pay income taxes or FICA on the amounts withheld from your pay. Therefore, over the course of the year, you will pay less in taxes and have more income than if you paid the contributions or expenses on an after-tax basis.

Please keep in mind that if you pay less tax because you elect to participate in the Plan, your social security benefits may be reduced slightly because you and your Employer will pay less FICA tax. Whether or not your social security benefits will actually be lower depends on a number of factors, such as your current age, your current earnings, and your future pay levels.

If you pay for health coverage for at least one dependent child, you may be able to claim a tax credit for some or all of the premium paid. However, you may not claim a tax credit for any amount withheld from your pay under this Plan for group health plan coverage. Depending on your income level and your required contribution amount, you may benefit both from the tax credit and this Plan by paying part of the required contribution on an after-tax basis and part of it on a pre-tax basis. You should consult with your tax advisor to determine your best course of action.

AVAILABLE BENEFITS

The Plan provides you the ability to make elections among the following benefit programs:

PRE-TAX PREMIUM PAYMENT PROGRAM

Under the Pre-Tax Premium Payment Program, you are able, with respect to the Employer's group health plan and certain other insurance programs offered by the Employer, as set forth in your election form, to do either of the following:

- Elect coverage and pay your required contributions with pre-tax dollars.

- Waive coverage and receive your entire compensation plus an additional amount, as determined by the Employer. You may use the additional amount to purchase benefits under the Plan or you may receive it as additional compensation through the Employer's payroll system.

The available coverages, the amount of the required contributions, and the additional amount, if any, that you may receive for waiving coverage are set forth in your election form. If you elect coverage, your election will not be final until your application for coverage is accepted by the benefit provider. In order to waive coverage under the Employer's group health plan, you must provide the Employer with written certification of alternative coverage with respect to each individual for whom coverage is being waived (i.e., you, your spouse, and each of your dependents).

If you are a Participant or a current or former employee who is not a participant but who is receiving compensation from the Employer, you may elect to pay COBRA premiums for group health coverage with pre-tax dollars in certain situations. For example, you can pay COBRA premiums with pre-tax dollars if you cease to be eligible for the Employer's group health plan because of a change in employment status but you continue working for the Employer. Also, if you are a new hire, you may elect to pay the COBRA premiums under your prior employer's group health plan with pre-tax dollars under this Plan.

If you elect Employer accident and health coverage for your dependent, the coverage will be on a tax-free basis if the dependent is any of the following:

- Your legally married spouse.

- Your natural child, your adopted child, a child placed with you for adoption, your step-child, or your foster child through the end of the month or the end of the calendar year the child turns age 26 (whichever time period is consistent with the Employer accident and health coverage), even if the child is not your tax dependent (i.e., is not your qualifying child or qualifying relative).

- Your qualifying child. A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his own financial support, and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18, or 23 if a full-time student. However, this age requirement is waived for a qualifying child who is totally disabled.

- Your qualifying relative. A qualifying relative is your child or other relative who receives from you over half of his financial support and who is not the qualifying child of you or any other individual. If your child is older than 18, or 23 if a full-time student, the child can be considered your qualifying relative even if he is too old to be your qualifying child.

If you elect Employer accident and health coverage for an eligible dependent other than one described above, you can pay premiums on a tax-free basis under the Plan. However, the fair market value of the dependent's accident and health coverage will be included in your gross income.

MEDICAL REIMBURSEMENT PROGRAM

The benefit offered under the Medical Reimbursement Program is the opportunity to be reimbursed for medical expenses that have not been paid by, and for which you will not seek

payment by, any other insurance policy or health care plan and that are paid for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. You may incur qualifying medical expenses for the following individuals:

- You.
- Your legally married spouse.
- Your natural child, your adopted child, a child placed with you for adoption, your step-child, or your foster child through December 31 of the calendar year the child turns age 26, even if the child is not your tax dependent (i.e., is not your qualifying child or qualifying relative).
- Your qualifying child. A qualifying child is your child or other relative who is younger than you, who lives with you, who does not provide more than half of his own financial support, and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18, or 23 if a full-time student. However, this age requirement is waived for a qualifying child who is totally disabled.
- Your qualifying relative. A qualifying relative is your child, other relative, or member of your household who receives from you over half of his financial support and who is not the qualifying child of you or any other individual.

Under current tax law, these qualifying expenses include, but are not limited to, the following:

- Expenses covered but not paid for by the Employer's group health plan, such as the amount paid before benefits begin (the deductible), the percentage of charges not paid by the plan (co-payment), and expenses over the maximum benefit amounts.
- Dental expenses, including preventive, diagnostic, orthodontic, and therapeutic care.
- Vision expenses, including examinations, eyeglasses, contact lenses, LASIK (laser) eye surgery, and seeing-eye dogs.
- Hearing expenses, including examinations and hearing aids.
- Physical examinations.
- Psychoanalysis, psychiatric therapy, learning disability counseling by a licensed professional, inpatient care and treatment (including special schooling if necessary for a mental or physical handicap), and services provided by a licensed psychologist.
- Acupuncture.
- Therapeutic treatment for drug addiction or alcoholism, including meals and lodging if necessary for the treatment.

- Medical equipment purchased or rented because of a medical problem, such as wheelchairs, crutches, and orthopedic shoes, or for the repair or replacement of prosthetic devices due to normal wear and tear.

- Medicines or other drugs prescribed by a doctor, including vitamins and birth control pills and devices.

- Over-the-counter drugs and medicines specifically prescribed by a physician, or insulin.

- Expenses for ambulance service and other travel costs to obtain health care, (i.e., gas and oil expenses for personal vehicles may be reimbursable or you may submit a claim for the maximum amount per mile prescribed by the IRS [parking and tolls are reimbursable under either method]).

- Weight-loss programs as treatment for obesity, including fees to join the program, but not food.

- Massage therapy prescribed by a physician to treat a medical condition.

- Body scans and other diagnostic procedures, including pregnancy kits, ovulation monitors, and on-site health fairs that measure health indicators such as blood pressure and cholesterol.

- Teeth whitening to correct discoloration caused by disease, birth defect, or injury.

- Cord blood storage for a child born with a medical condition that may require cord blood in the future, but not if storing is just in case of a future need.

- Other medical expenses qualifying as legitimate deductions for federal income tax purposes, subject to the approval of the Plan Administrator.

Current tax law prohibits a Medical Reimbursement Program from reimbursing the following types of expenses for a plan year:

- Expenses incurred before the beginning or after the end of the current plan year.

- Expenses incurred for cosmetic surgery or similar procedures unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. The term “cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

- Expenses for non-prescription drugs and medicines unless specifically prescribed by a physician or if the drug is insulin.

- Premiums for health plan coverage. However, premiums for Employer health plan coverage may be paid on a pre-tax basis under the Pre-Tax Premium Payment Program.

- Long-term care expenses and premiums for long-term care insurance.

- Any expense incurred before the effective date of the Medical Reimbursement Program, before you became an eligible employee of the Employer, or while you were not participating in the Medical Reimbursement Program.

- Any expense incurred that is in excess of the amount of benefits you elect under the Medical Reimbursement Program for the plan year.

Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, notwithstanding this general rule, orthodontia services may be reimbursed before the services are provided but only to the extent that you have actually made payment in advance in order to receive the services. Such orthodontia services are considered to be incurred when you make the advance payment.

The amount available for reimbursement of qualifying medical expenses is the entire amount you have elected for the plan year minus any reimbursement previously made from your account for expenses incurred during the plan year. The Employer may establish the maximum and minimum amounts you may elect to be reimbursed under the Medical Reimbursement Program for a plan year. Federal law does not allow you to contribute more than $2,600 to your account under the Medical Reimbursement Program for a plan year. This amount may be increased in future plan years for changes in the cost of living.

Please note the following special rules for participants in health savings accounts (HSA): An HSA is a tax-favored IRA type of account established for an eligible individual covered only by a qualified high-deductible health plan. If you are enrolled in the Employer's high-deductible health plan and you contribute to an HSA (or the Employer contributes for you), you may not receive coverage under a non-high-deductible health plan. If you have coverage under a non-high-deductible health plan, you are ineligible for the HSA. A Medical Reimbursement Program is generally considered a non-high-deductible health plan for this purpose.

If you are not a participant in the Employer's Health Savings Account Program, but you have a spouse or dependent who participates in an HSA, you and your dependents should not participate in the Medical Reimbursement Program portion of the Plan for the entire plan year in which your spouse or dependent participates in the HSA in order for your spouse or dependent to be eligible for the HSA.

If you are called to active military service for a period of at least 180 days, you may take a "qualified reservist distribution" from your Medical Reimbursement Account in accordance with a federal law known as the HEART Act. In order to obtain a distribution you must provide Employer with a copy of your active-duty order and make the request in writing before the end of the year in which you are called to active duty. The amount of the distribution may not exceed the current unused balance in your Medical Reimbursement Account at the time the distribution is processed. The distribution will be included in your taxable income. The distribution request will be processed as soon as administratively feasible and in no event later than 60 days from the date the request was submitted.

The Medical Reimbursement Program is subject to the HIPAA privacy and security rules. You will receive a notice of the Employer's privacy practices, which will explain in detail the HIPAA privacy rules and your privacy rights.

DEPENDENT CARE REIMBURSEMENT PROGRAM

The benefit offered under the Dependent Care Reimbursement Program is the opportunity to be reimbursed for dependent care expenses that you incur to enable you to be gainfully employed. The Internal Revenue Code defines who is considered your dependent for this purpose. Your dependent includes a **qualifying child** who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her financial support for the year, and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the non-custodial parent for income tax purposes. Your dependent also includes a **qualifying relative** such as your parent who receives over half of his or her financial support for the year from you.

Examples of eligible expenses include the following:

- Nursery schools and day care centers.
- Dependent care centers that provide day care—not residential care—for disabled dependent adults (if the disabled dependent adult spends at least eight hours a day in your household).
- Individuals (other than your dependents or children under the age of 19) who provide care for your dependent children or disabled dependent adults in or outside of your home. However, if the care is provided to a disabled dependent adult outside your home, the adult must spend at least eight hours a day in your household.
- Expenses for household services related to the care of a dependent in your home.

Current law prohibits a dependent care reimbursement program from reimbursing the following types of expenses for a plan year:

- Amounts claimed as a deduction or credit for federal income tax purposes.
- Services for someone who is not your dependent, as defined in the Internal Revenue Code.
- Household services that are not performed in part for the benefit of your dependent.
- Expenses incurred before the beginning or after the end of the current plan year.
- Any expense incurred before the effective date of the Dependent Care Reimbursement Program, before you became an eligible employee of the Employer, or while you were not participating in the Dependent Care Reimbursement Program.

- Any expense incurred that is in excess of the amount of benefits you elect under the Dependent Care Reimbursement Program for the plan year.

Current tax laws dictate the maximum amount that you may elect under the Dependent Care Reimbursement Program. Currently, the law limits the maximum to the lesser of the following amounts per calendar year: (a) $5,000 ($2,500 if you are married and file separate tax returns); (b) your earned income; or (c) the earned income of your spouse (if you are married at the end of the year). If you earn less than $10,000 or your spouse earns less than $5,000, the limit is the lesser of your spouse's pay or one-half of your pay. If your spouse is a full-time student or is mentally or physically incapable of caring for himself or herself during any month in which you have dependent care expenses, your spouse will be considered to have earned, for each such month, at least $250 if you have one dependent or $500 if you have two or more dependents.

The amount of any reimbursement is limited to the balance in your dependent care account at the time of the claim.

In order to exclude from income, and thereby avoid tax on, amounts received as reimbursement under the Dependent Care Reimbursement Program, you must report the correct name, address, and taxpayer identification number (in the case of an entity) or social security number (in the case of an individual) of your dependent care provider both on your claim for reimbursement and on your federal income tax return (Form 2441). (Note: If the claim form does not require you to list the social security number of your dependent care provider, you will need to certify that you have obtained this information.) If the dependent care provider is a tax-exempt organization described in Section 501(c)(3) of the Internal Revenue Code, you are not required to report the provider's taxpayer identification number. However, you must report the correct name and address of the provider and write "tax-exempt" in the space where the taxpayer identification number of the provider generally would be reported.

ELIGIBILITY

PRE-TAX PREMIUM PAYMENT PROGRAM

The eligibility requirements for the Pre-Tax Premium Payment Program are the same as the requirements of the Employer's group health plan and any other insurance programs covered by the Pre-Tax Premium Payment Program, including coverage from the SHOP Exchange, as provided by the Patient Protection and Affordable Care Act. If you are an eligible employee as of the effective date of the Plan, you will be immediately eligible to participate. Otherwise, you will become eligible to participate on the day you satisfy the eligibility requirements.

MEDICAL AND DEPENDENT CARE REIMBURSEMENT PROGRAMS

All eligible employees of the Employer who are eligible to participate in the Employer's group health plan are eligible to participate in the Medical and Dependent Care Reimbursement Programs. If you are an eligible employee, you will be eligible to participate in the Medical and Dependent Care Reimbursement Programs on the day you become eligible to participate in the Employer's group health plan.

If you are an eligible employee as of the effective date of the Plan, you will be immediately eligible to participate. Otherwise, you will become eligible to participate on the day you satisfy the eligibility requirements.

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing your benefits under the Plan. You may not change your election during the plan year unless you have a change in status, as described below.

INITIAL BENEFIT SELECTION

Generally, you must make an election by the date that you become a Participant in the Plan. The Employer will inform you of the election procedure. The election procedure may require completion and return of a written election form or completion of your election electronically such as through an online or telephonic system. The election will remain in effect through the last day of the plan year unless you have a change in status, as described below. Generally, if you do not make an election before the date that you become a Participant in the Plan, you will receive a standard benefit program as periodically set by the Employer. You may pay for the standard benefit program by reducing your pay on a before-tax basis. However, you will not be eligible to reduce your pay beyond the amount needed to pay for the standard benefit program, and you will not be eligible to purchase any other benefits under the Plan. If you are a new employee who becomes eligible on your date of hire, the election will be retroactively effective to your first day of employment if you make your election within the next 30 days after you start working. See the Health Savings Account Program section of this Summary Plan Description for special election rules regarding the HSA program.

When you make your election, an ASR Health Benefits Card will be sent to you. Use of the debit card indicates your agreement to, and acceptance of, the terms of the ASR Health Benefits Card user agreement. See the Claims Procedure section of this Summary Plan Description for further details concerning the debit card. For more information on the debit card program, visit the ASR Health Benefits Website at www.asrhealthbenefits.com.

ANNUAL BENEFIT ELECTION

You will have the opportunity to make new elections during the open enrollment period before the first day of each subsequent plan year. The new election will be effective as of the first day of the following plan year and will remain in effect through the last day of the following plan year unless you have a change in status, as described below. Further, your debit card will be credited with a new balance for the Medical Reimbursement Program and Dependent Care Reimbursement Program as of the first day of the following plan year in accordance with your new election.

For the Pre-Tax Premium Payment Program, if you do not make a new election during the open enrollment period, you will receive a standard benefit program as periodically set by the Employer. You may pay for the standard benefit program by reducing your pay on a before-tax basis. However, you will not be eligible to reduce your pay beyond the amount needed to pay

for the standard benefit program, and you will not be eligible to purchase any other benefits under the Plan.

For the Medical Reimbursement Program and the Dependent Care Reimbursement Program, if you do not make a new election during the open enrollment period, the Employer will deem that you have elected to waive participation in the Medical Reimbursement Program and the Dependent Care Reimbursement Program for the next plan year, and your debit card will not be valid for the next plan year.

For the Health Savings Account Program, see the Health Savings Account Program section of this Summary Plan Description.

FORFEITURE OF UNUSED AMOUNTS

Under IRS regulations, generally, any money left in your Dependent Care Reimbursement Account at the end of the plan year must be forfeited and may not be refunded to you. In deciding how much of your compensation to direct toward benefits under the Dependent Care Reimbursement Program, you must estimate your expected expenses for the upcoming year carefully.

However, up to $500 of any unused amount in your Medical Reimbursement Account may be carried over to the next plan year if you have elected to contribute pre-tax compensation reductions to your Medical Reimbursement Account for that next plan year. This amount will be available immediately after the claims submission period (that is, 90 days following the last day of the plan year). At the end of the plan year (September 30), the unused amount in your Medical Reimbursement Account in excess of $500 must be forfeited.

Forfeited amounts will be used first to offset reasonable administrative expenses. Any remaining forfeitures may be retained by the Employer or divided on a uniform basis and either credited to Participants' accounts for use in the following plan year or distributed on a per capita basis to each person who was a Participant on the last day of the current plan year.

CHANGING YOUR ELECTION DURING A PLAN YEAR

As a general rule, you may change your benefit election annually only during an open enrollment period. However, you may change your election during a plan year in certain situations where federal law permits a new election (but in no event may you change your benefit election for a plan year after that plan year ends). The next sections describe these situations. Note: These rules do not apply to the Health Savings Account Program. See the Health Savings Account Program section of this Summary Plan Description for details.

CHANGE IN STATUS

A change in status is an exception to the rule prohibiting any change in your benefit election during a plan year. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation, and annulment.

- An event that changes the number of your dependents, including birth, adoption, placement for adoption, and death of your dependent.

- An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual's eligibility for benefits.

- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage because of the attainment of a specified age, student status, or any similar circumstance.

- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Plan only if the election change is on account of and corresponds with the change in status that affects eligibility for coverage. Notwithstanding this general rule, the following special rules apply:

- If you want to decrease or cancel Employer-provided group health, dental, or vision coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent on account of a legal marital or employment change in status, the change will be permitted only if you actually are obtaining or will be obtaining coverage under the other plan.

- With respect to your Medical Reimbursement Account, you may elect to decrease your annual contribution amount, but not below the amount the Plan has already reimbursed you for the plan year.

- With respect to your Dependent Care Reimbursement Account, an election change must be on account of and correspond with a change in status that affects dependent care expenses; further, you may change your election if your dependent attains age 13, becomes totally disabled, or is no longer totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the Plan Administrator. If you do not make a new election within 30 days after the change in

status, you must wait until the next open enrollment period to change your election. Further, the Plan Administrator will approve any new election involving an HMO or independent, third-party insurer to the extent permitted by the HMO or independent, third-party insurer.

CHANGES TO COORDINATE WITH THE AFFORDABLE CARE ACT

Under the Affordable Care Act, you may become eligible for Employer-provided group health coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of fewer than 30 hours of service per week. In this situation, you can elect to cancel Employer-provided group health coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage for yourself and any affected family members provided that you enroll in another plan that provides "minimum essential coverage" (as that term is defined in the Affordable Care Act) and that is effective no later than the first day of the second month following the month that includes the date your Employer-provided group health coverage is revoked.

Similarly, if you are eligible to enroll in a "qualified health plan" (as that term is defined in the Affordable Care Act) through an exchange during a special enrollment period or annual open enrollment period, you can elect to cancel Employer-provided group health coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan that is effective no later than the day immediately following the date your Employer-provided group health coverage is revoked.

FMLA LEAVE AND OTHER APPROVED LEAVES OF ABSENCE

If you take an FMLA leave, you may continue or revoke your elections regarding Employer-provided group health, dental, or vision coverage or your Medical Reimbursement Account even if you do not otherwise have a change in status. If you take an FMLA leave, the following rules apply:

- If you take an FMLA leave to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA leave is 26 weeks per 12-month period.

- You may continue or revoke your election of these benefits when you begin your FMLA leave.

- If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact the Employer to discuss the procedures for making the contributions.

- If you terminated your health, dental, or vision coverage during the FMLA leave, you may elect to reinstate it when you return to work. Reinstatement will occur immediately.

- You have the same election rights during the FMLA leave as an actively working Participant during an open enrollment period and if the Employer offers a new or significantly improved benefit or coverage option during a plan year.

- If you are entitled to receive an additional amount for waiving health coverage, you will not be entitled to this additional amount during an unpaid FMLA leave.

- If you terminate coverage in your Medical Reimbursement Account during the FMLA leave, your account cannot be used to reimburse expenses incurred during the FMLA leave. Your total benefits during the plan year may be reduced on a pro rata basis for the time period in which your coverage was not in effect.

- If you do not return to work at the end of an FMLA leave, your participation in the Plan will terminate, unless the Employer grants you an additional non-FMLA approved leave of absence at the end of the FMLA leave (see statement below).

The rules described above will also apply if you go on a non-FMLA approved leave of absence.

SPECIAL ENROLLMENT RIGHTS UNDER HIPAA

You may have special rights under HIPAA to enroll in Employer-provided group health, dental, or vision coverage in the following situations:

- You have lost other group health coverage. This loss could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

- You acquire a new dependent by marriage, birth, or adoption. You must make your new election within 30 days after the event occurs.

- Your Medicaid or a state's Children's Health Insurance Program (CHIP) coverage is terminated as a result of a loss of eligibility, or you become eligible for a premium-assistance subsidy under Medicaid or a CHIP to obtain coverage under Employer's group health coverage. You must make your new election within 60 days after the event occurs.

COURT ORDER

You may change your election regarding Employer-provided group health, dental, or vision coverage because of a court order resulting from a divorce, legal separation, or change in legal custody that requires health coverage for one or more of your children. Specifically, you may do either of the following:

- Elect coverage for the child if the court order requires you to add the child to the Employer-provided coverage in which you are enrolled.

- Cancel coverage for the child if the court order requires the spouse, former spouse, or other person to provide coverage and the other coverage is actually provided.

MEDICARE OR MEDICAID COVERAGE

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce Employer-provided group health, dental, or vision coverage for that individual. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase Employer-provided group health, dental, or vision coverage for that individual.

COST AND COVERAGE CHANGES

If the cost of coverage under the Employer's group health plan and any other insurance programs of the Employer in which you participate changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase for an option is significant, you may agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease for an option is significant, you may elect to begin participation in the reduced-cost option even if you did not previously elect it for the plan year.

With respect to your Dependent Care Reimbursement Account, if the cost of your dependent care provider changes during the plan year, you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

If coverage under the Employer's group health plan and any other insurance programs of the Employer in which you participate is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. Further, if the Employer offers a new or significantly improved benefit or coverage option, you may prospectively elect that option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other group health plan, you may make a corresponding election change under this Plan.

LIMITATIONS ON SUBSEQUENT BENEFIT ELECTIONS

If you waive participation in any of the Employer's insurance programs for yourself or your family, special limitations may apply to the individuals for whom you waive coverage if they later want to participate. For example, the individual may be required to wait until an open enrollment period to enroll for coverage.

TERMINATION OF PARTICIPATION

If you stop working in an eligible job classification or terminate employment, your participation in the Plan will terminate on the last day you are an eligible employee.

Except for the special rules regarding the pre-tax payment of premiums for COBRA, upon termination of participation, you will be ineligible to have additional compensation reductions allocated to purchase coverage under the Employer's group health plan and any other insurance programs for which contributions are paid under the Pre-Tax Premium Payment Program, or to receive additional compensation for waiving coverage. Your continued participation and coverage under the Employer's group health plan and any other insurance programs will be determined under the terms and conditions of each of those separate plans or programs.

Upon termination of participation, you will also be ineligible to have additional amounts allocated to your Medical Reimbursement Account and Dependent Care Reimbursement Account, and your debit card will automatically be canceled. If you have an amount remaining in your Medical Reimbursement Account, you may continue to submit claims for reimbursement of qualifying expenses incurred before you terminated participation. However, you are not eligible to be reimbursed for claims for qualifying expenses incurred after you terminated participation unless you continue to participate in the Plan as described below. If you have an amount remaining in your Dependent Care Reimbursement Account upon termination of participation, this amount may continue to be applied toward the reimbursement of claims for eligible expenses incurred until the date your participation terminated.

You have the option of continuing to participate in your Medical Reimbursement Account after you terminate participation to the extent required by the federal law known as COBRA. Under COBRA, if the amount contributed to your Medical Reimbursement Account for the plan year exceeds the claims you have submitted for the plan year, you will generally be eligible to continue to participate for the remaining portion of the plan year during which your participation terminated. COBRA is generally not available for a subsequent plan year unless, pursuant to federal regulations, certain requirements are met (for example, your Medical Reimbursement Account is not considered an excepted benefit under HIPAA).

If you are eligible to elect COBRA with respect to your Medical Reimbursement Account, you may continue participation by making after-tax contributions to the Plan on a monthly basis in an amount equal to 102% of the compensation reductions that were allocated to your Medical Reimbursement Account each month before you terminated participation. After-tax contributions for a month must be paid by the first day of that month. However, there is a 30-day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

In order to protect your rights to COBRA, it is important that you inform the Plan Administrator of any changes in your address. If you have questions regarding COBRA, you should contact the Plan Administrator at the address and telephone number found on page 2 of this Summary Plan Description.

For information about your rights under COBRA, HIPAA, and other laws affecting the Plan, you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA's Website at

www.dol.gov/ebsa. Addresses and telephone numbers of the regional and district offices are available through EBSA's Website.

If you participate in the Medical Reimbursement Account and you go on a military leave of absence, the Employer must comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) with respect to the Plan. USERRA provides rights to continue participation in the Medical Reimbursement Account during a military leave of absence.

Further, if you terminate employment and are rehired during the same plan year, there are special rules that may restrict your participation until the following plan year. You should contact the Employer for further details regarding these special eligibility rules.

CLAIMS PROCEDURE

PRE-TAX PREMIUM PAYMENT PROGRAM

In order to receive benefits from the coverages offered under the Pre-Tax Premium Payment Program, you should follow the claims procedure outlined in the Summary Plan Description or information booklet from the benefit provider. The existence of this Plan will not cause the Employer to guarantee benefits under its group health plan or any other insurance programs. Benefits under the Employer's group health plan and any other insurance programs will be exclusively provided under each of those separate plans or programs. If there is any conflict or inconsistency between the description of benefits contained in this Plan and the description of benefits contained in the Employer's group health plan or other insurance programs, the terms of the group health plan or the other insurance programs will control. If you have any questions about your eligibility to pay your required contributions for these benefits through this Plan, you should contact the Plan Administrator.

MEDICAL AND DEPENDENT CARE REIMBURSEMENT PROGRAMS

In order to receive reimbursement of expenses under the Medical Reimbursement Program or Dependent Care Reimbursement Program, you must file a benefit claim form with the Claim Administrator, together with a receipt or proof of payment and any additional information that may be required by the Plan Administrator or the Claim Administrator. The Plan Administrator or the Claim Administrator will have benefit claim forms available for your use. Within 90 days after receiving your claim (unless circumstances justify a longer period of time), the Plan Administrator will either pay or deny it. You must apply for reimbursement no later than 90 days following the last day of the plan year. Further, if you terminate employment and your participation in the Plan before the end of a plan year, you must file all claims for reimbursement no later than 90 days after the date of termination.

You may use the ASR Health Benefits Card to pay for eligible expenses but only at specific locations, such as a pharmacy or a doctor's office. By law, merchants may choose to require either a signature debit or a personal identification number (PIN) debit. You can obtain a PIN by calling (866) 898-9795. If a service provider will not accept the debit card, you must file a benefit claim form as described above. You are responsible for all of the charges on the debit

card. If you use the card for an expense not deemed to be "eligible," the Plan Administrator may require additional information about the expense and may ask you to repay the amount debited.

If a Claim Administrator is appointed, the Claim Administrator merely processes claims and does not ensure that any expense covered by the Plan will be paid. The Plan Administrator or the Claim Administrator will process complete and proper claims for reimbursement promptly. However, in the event there are delays in processing claims, Participants will have no greater rights to interest or other remedies against the Plan Administrator or the Claim Administrator than is otherwise afforded by law.

The Plan offers the carryover rule, which is an exception to the normal forfeiture rule under the Plan and is authorized by the Internal Revenue Service. Under the carryover rule, if you are a participant in the Plan and have an unspent balance in your Medical Reimbursement Account at the end of the plan year, the balance, up to a maximum of $500, may be carried over and used to pay for qualifying medical expenses incurred in the following plan year if you elect to participate in the Plan for that following plan year.

CLAIMS APPEAL

If the Plan Administrator or Claim Administrator denies your claim under the Plan, in whole or in part, it will notify you in writing of the reasons for the nonpayment or denial, the specific provisions of the Plan on which the nonpayment or denial was based, a description of any additional information needed to process the claim, and an explanation of the claim review procedure. If you do not receive written notice of the claim decision or the need for an extension within 90 days after you submitted the claim, you should consider the claim to be denied.

Within 60 days after you receive the notice of nonpayment or denial, you may submit a written request for reconsideration to the Plan Administrator, along with documents or records in support of the appeal. You may review pertinent documents and submit issues and comments in writing. Within 60 days after receiving a request for review (unless circumstances justify a longer period of time), the Plan Administrator will review the claim denial and provide you with written notice of the review decision. The notice will explain the reason for the decision with specific reference to the plan provisions on which the decision was based. Decisions of the Plan Administrator are final and binding.

The Plan will not be required to pay interest on any claim for benefits, regardless of when paid. Also, if a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check will be dishonored.

HEALTH SAVINGS ACCOUNT PROGRAM

Under the Health Savings Account Program, an HSA account is established for an eligible individual covered under a qualified High-Deductible Health Plan. Contributions are fully vested when made and investment earnings on the HSA grow tax-free. Distributions from the HSA are tax-free if they are used to pay qualified medical expenses. Unused benefits can be carried forward and used in future years.

The HSA benefit is included in the Flexible Spending Plan because this Plan provides a mechanism for contributions to be made to your HSA. If permitted by the Employer, you may elect to have before-tax compensation reductions or any additional compensation that may be provided by the Employer for waiving employer-provided medical coverage contributed to your HSA. In addition, the Employer may make an Employer contribution on your behalf to your HSA. The amount, if any, provided by the Employer will be based on a formula determined by the Employer, and the Employer will communicate that amount to you during the open enrollment period.

PARTICIPATION AND ELECTION RULES

You are eligible to participate in the Health Savings Account Program if you are covered under a qualified High-Deductible Health Plan and you are not covered under any health plan that is not a qualified High-Deductible Health Plan.

Your participation in the Health Savings Account Program may begin on the first day of the month on or after the later of the effective date of the HSA or the date you became a Participant in the Plan (see the Eligibility section). You may elect to make pre-tax contributions to your HSA beginning as of your initial date of eligibility. If you do not make an election within a reasonable period of time before your initial date of eligibility, you may do so as of any later date in accordance with procedures established by the Plan Administrator. That is, the normal initial and annual election procedures of the Plan do not apply to HSAs, nor do the restrictions on making mid-year election changes. Once you make an election, it will remain in force (including for subsequent plan years) unless you make a change. You can elect to increase, decrease, stop, or begin your pre-tax HSA contributions as of any prospective date in accordance with procedures established by the Plan Administrator.

If you terminate employment or otherwise become ineligible to participate in the Health Savings Account Program, your participation will generally terminate as of the last day of the month during which you are no longer an eligible Participant in the Plan.

ADDITIONAL INFORMATION

As aforementioned, the Health Savings Account Program is included in the Flexible Spending Plan because this Plan provides a way for contributions to be made to your HSA. As a result, the other rules concerning the HSA and High-Deductible Health Plan are not part of this Plan but will be provided to you in the communication materials regarding the HSA and High-Deductible Health Plan benefits.

PLAN AMENDMENT OR TERMINATION

The Plan Sponsor may amend or terminate this Plan at any time in accordance with the terms of the Plan. If the Plan Sponsor amends or terminates the Plan, the amendment or termination will not retroactively affect your rights to benefits for any expenses incurred before the amendment or termination, unless necessary to comply with applicable laws or regulations.

INDEMNIFICATION

As a condition for participating in the Plan, you will be required to indemnify and reimburse the Plan for any expense or cost incurred (including attorney fees) on account of the payment of a benefit that should not have been paid or reimbursed under the Plan.

ADMINISTRATION

The Plan Sponsor is the Plan Administrator, and the Plan Administrator is charged with the administration of the Plan. The Plan Administrator has the discretionary authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of the payment of benefits, including the power to correct any defect, supply any omission, or reconcile any inconsistency. The Plan Administrator will exercise its discretionary authority in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the Plan Administrator has the discretionary authority to construe and interpret the terms of the Plan.

The Plan Sponsor may delegate all or a portion of its duties as Plan Administrator to an administrative committee. If the Plan Sponsor establishes an administrative committee, the Plan Sponsor will communicate the addresses and telephone numbers of the committee members to you in writing. The administrative committee will have the powers of the Plan Administrator.

The Plan Administrator may also delegate some of its duties to a Claim Administrator, including the duty to process claims. If the Plan Administrator appoints a Claim Administrator, the Claim Administrator's name, address, and telephone number will be listed on page one of this Summary Plan Description. However, the Claim Administrator will have no power to modify the Plan or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.