



**CHRISTIAN SCHOOLS
INTERNATIONAL**

CSI FLEXIBLE BENEFITS PLAN

Effective Date: September 1, 2002

TABLE OF CONTENTS

	<u>Page</u>
SECTION I ESTABLISHMENT AND PURPOSE OF THE PLAN	1
SECTION II DEFINITIONS	1
SECTION III PARTICIPATION	4
3.1 Commencement of Participation	4
3.2 Termination of Participation	5
3.3 Continuation Coverage	5
3.4 Participation After Reemployment	6
3.5 Leave of Absence	6
SECTION IV BENEFITS	6
4.1 This Section Generally	6
4.2 Benefit Options	6
4.3 Election of Benefits	7
4.4 Changes in Benefit Election During the Plan Year	8
4.5 Change in Status	11
4.6 Consistency Requirement	11
4.7 FMLA Leaves of Absence	12
4.8 Non-FMLA Leaves of Absence	14
4.9 Nondiscrimination Rules	14
4.10 Maximum Compensation Reductions and Maximum Employer Contributions	14
SECTION V HEALTH CARE FSA	15
5.1 Establishment of Health Care FSA	15
5.2 Crediting of Health Care FSA	15
5.3 Covered Expenses	15
5.4 Reimbursement of Qualifying Health Care Expenses	15
5.5 Claims for Reimbursement	16
5.6 Forfeiture of Health Care FSA	16
5.7 Special Nondiscrimination Rule	16
5.8 HIPAA	16
5.9 Compliance with ERISA and Laws Applicable to Group Health Plans	17
SECTION VI DEPENDENT CARE FSA	17
6.1 Establishment of Dependent Care FSA	17
6.2 Crediting of Dependent Care FSA	18
6.3 Covered Expenses	18
6.4 Reimbursement of Qualifying Dependent Care Expenses	18
6.5 No Reimbursement for Amounts Paid to Related Individuals	19
6.6 Claims for Reimbursement	19
6.7 Dependent Care Certification Statement	19
6.8 Statement of Expenses	20

6.9	Forfeiture of Dependent Care FSA	20
6.10	Special Nondiscrimination Rules	20
SECTION VII	FUNDING	21
7.1	Funding of Benefits	21
SECTION VIII	ADMINISTRATION	21
8.1	Plan Administrator and Named Fiduciary	21
8.2	Powers of Plan Administrator	21
8.3	Administrative Services	22
8.4	Appeal Procedure	22
8.5	Standard of Care.....	22
8.6	Inability to Locate Payee.....	22
8.7	Effect of Mistake.....	23
SECTION IX	RIGHTS OF PARTICIPANTS	23
9.1	Employment Rights.....	23
9.2	Participants' Rights.....	23
9.3	Spendthrift Provision.....	23
SECTION X	ADOPTION BY PARTICIPATING MEMBER SCHOOLS.....	23
10.1	Adopting Participating Member Schools	23
SECTION XI	PLAN AMENDMENT AND TERMINATION	23
11.1	Amendment of Plan.....	23
11.2	Termination of Plan.....	23
11.3	Limitations on Amendment or Termination.....	23
SECTION XII	MISCELLANEOUS PROVISIONS	24
12.1	Age	24
12.2	Uniformity of Treatment	24
12.3	Effect Upon Other Compensation-Related Plans	24
12.4	Construction	24
12.5	Governing Law.....	24
12.6	ERISA	24
SIGNATURE PAGE.....		25
APPENDIX A - Participating Member Schools.....		26

SECTION I – ESTABLISHMENT AND PURPOSE OF THE PLAN

The CSI Flexible Benefits Plan (the "Plan") has been established by the Trustees of Christian Schools International (CSI) and has been made available to CSI and Participating Member Schools of CSI since September 1, 1990. This document amends and restates the terms of the Plan effective September 1, 2002. The purpose of the Plan is to allow Eligible Employees of Participating Member Schools to choose between certain tax-free benefits or additional cash compensation so that Employees may receive benefits that best meet their individual needs.

CSI intends that the Plan qualify as a "cafeteria plan" under Section 125 of the Code. Further, the Plan is to be interpreted in a manner consistent with the requirements of Section 125 of the Code.

CSI may offer a choice among additional benefits that may not constitute qualified benefits, but nothing in this Plan should be construed as offering anything but such nontaxable benefits, except to the extent that CSI may otherwise specifically provide by written amendment to the Plan.

SECTION II - DEFINITIONS

The following terms and phrases used in the Plan and other documents relating to the Plan shall have the meanings described in this Section unless the context clearly indicates another meaning. All references to specific Sections shall refer to Sections of the Plan unless otherwise stated.

"Benefit Administrator" means the entity designated by CSI to be the contract administrator responsible for the administration of some or all of the benefits under the Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Compensation" means salary, hourly wages, overtime pay, incentive pay, bonuses, commissions, severance pay and amounts described in Section 4.2(d) which are paid to a Participant by the Participating Member School during a Plan Year in connection with personal services provided by the Participant.

"Compensation Reductions" means the amount by which a Participant reduces his Compensation to purchase benefits under the Plan (i.e., pre-tax contributions to the Plan). Compensation Reductions shall be deducted in equal amounts from a Participant's paychecks during the Plan Year.

"CSI" means Christian Schools International.

"Dependent" means a Spouse and a person who is a Dependent of the Participant within the meaning of Section 152(a) or Section 21(e)(5) of the Code.

"Dependent Care Flexible Spending Account (FSA)" means the Flexible Spending Account established and maintained by CSI and the Participating Member Schools under Section VI to record the allocation of a Participant's Compensation Reductions for the reimbursement of Qualifying Dependent Care Expenses.

"Dependent Care Services" mean dependent care services for a Qualifying Individual, which may be performed either inside or outside the Participant's home. However, if the Dependent Care Services are

performed outside the Participant's home, the Dependent Care Services must be provided to a Qualifying Individual who also satisfies one of the following requirements:

- the Qualifying Individual is a Dependent who is under the age of 13; or
- the Qualifying Individual is a Spouse or Dependent (regardless of the Dependent's age) who is either physically or mentally incapable of self-care and regularly spends at least eight hours per day in the Participant's home.

“Earned Income” means all income derived from wages, salaries, tips, self-employment and other employee Compensation (such as disability benefits), but excluding amounts received:

- under the dependent care assistance benefit of the Plan or any other dependent care assistance program under Code Section 129;
- as a pension or annuity; or,
- as unemployment or workers’ compensation.

“Eligible Employee” means teaching staff working 500 or more classroom hours per year, or an Employee who is reasonably expected by the Participating Member School under the conditions and classification of his or her employment to work at least 20 hours per week.

“Eligibility Date” means the first day of the first calendar month coincident with or following the first day of employment as an Eligible Employee.

“Employee” means any individual who is considered to be in a legal employer-employee relationship with the Participating Member School for Federal withholding tax purposes. A person who is treated as an independent contractor or a leased employee for tax purposes is not an Employee. If an independent contractor or leased employee is subsequently characterized as a common-law employee of the Participating Member School, the person shall not be eligible to participate in the Plan for any time period before the date on which the person is determined to be a common-law employee. The term “Employee” also includes “former Employees” for the limited purpose of allowing continued eligibility for benefits under the Plan (either through electing COBRA coverage for the Health Care FSA or to “spend down” their Dependent Care FSA account balance as described in Section 6.4) for the remainder of the Plan Year in which an Employee ceases to be employed by the Participating Member School.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“Flexible Spending Accounts (FSAs)” mean the bookkeeping accounts established and maintained to record the amount of health care reimbursement benefits and dependent care reimbursement benefits available to a Participant under Sections V and VI of the Plan.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“Health Care Flexible Spending Account (FSA)” means the Flexible Spending Account established and maintained by CSI under Section 5.1 to record the allocation of a Participant's Compensation Reductions for the reimbursement of Qualifying Health Care Expenses.

“Highly Compensated Individual” means an individual defined under Section 105(h), 125(e)(2) and 414(q) of the Code as a “highly compensated individual” or a “highly compensated employee”.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“Household Services” means household services performed in and about the Participant’s home which are ordinary and necessary to the maintenance of a household and which are attributable in part to the care of a Qualifying Individual. For example, amounts paid for the services of a domestic maid or cook are expenses for Household Services if parts of the services are provided to the Qualifying Individual.

“Key Employee” means any Employee or former Employee who, during the Plan Year, was:

- (a) An officer of the Participating Member School whose annual Compensation is greater than \$130,000 (as indexed);
- (b) A more-than-5% owner of the Participating Member School; or
- (c) A more-than-1% owner of the Participating Member School with annual Compensation in excess of \$150,000.

“Open Enrollment Period” means, with respect to each Plan Year, the time period established by the Participating Member School for a Participant to make his benefit elections for that Plan Year. The Open Enrollment Period shall be determined by the Participating Member School and communicated to Participants before the beginning of each Plan Year. The elections made during the Open Enrollment Period shall become effective the first day of the following Plan Year.

“Participant” means an Employee who has satisfied the participation requirements under Section III.

“Participating Member School” means CSI and member schools of CSI who have duly adopted this Plan, as required in Section X. Appendix A contains a list of all Participating Member Schools.

“Plan” means the CSI Flexible Benefits Plan, as described herein.

“Plan Administrator” means the named fiduciary responsible for the operation and administration of the Plan. CSI shall be the Plan Administrator.

“Plan Year” means the 12-consecutive-month period beginning on September 1.

“Pre-Tax Premium Contributions” means any pre-tax premium contributions to the School-sponsored Benefit Plan(s) as defined herein.

“School-sponsored Benefit Plan(s)” means any group or individual insurance benefit plan or plans including, but not limited to, medical, dental, vision and/or prescription drug benefits (including an HMO) that the Participating Member School periodically makes available to Eligible Employees and their Dependents.

“Spouse” means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care FSA benefit, the term “Spouse” shall not include (a) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

“Student” means an individual who, during each of five calendar months during a Plan Year, is a full-time Student at an educational institution. For purposes of this Section, “educational institution” means a college or university that satisfies the following requirements:

- (a) Its primary function is to present formal instruction;
- (b) It normally maintains a regular faculty and curriculum; and
- (c) It normally has a regularly enrolled body of Students in attendance at the place where its educational activities are regularly conducted.

“Qualified Benefits” mean benefits which are generally not includable in a Participant's gross income and which may be purchased under a cafeteria plan pursuant to Section 125(f) of the Code.

“Qualifying Dependent Care Expenses” means all eligible employment-related expenses incurred by a Participant for Dependent Care Services or for the cost of sending his child to a qualifying dependent care service provider which are paid to a person who is not:

- a Dependent of the Participant;
- the Participant’s Spouse; or,
- a child of the Participant under the age of 19 years.

“Qualifying Health Care Expenses” mean expenses incurred by a Participant, Spouse, or Dependent for medical services and supplies as defined in Section 213 of the Code, but only to the extent that the Participant, Spouse or Dependent incurring the expenses is not reimbursed for the expenses through insurance or any other source. The cost of health coverage (premiums) under any group plan or individual policy, including health coverage maintained by the Participating Member School for its employees, shall not constitute a Qualifying Health Care Expense for purposes of the Health Care FSA.

“Qualifying Individual” means:

- (a) a Dependent who is under the age of 13;
- (b) a Dependent who is either physically or mentally incapable of self-care, regardless of the Dependent’s age; or
- (c) a Spouse of the Participant who is either physically or mentally incapable of self-care. The status of a person as a Qualifying Individual is determined on a day-to-day basis.

SECTION III - PARTICIPATION

3.1 Commencement of Participation. Each Eligible Employee may participate in the Plan for that Plan Year if he provides the Participating Member School with a completed enrollment form by the end of the 30-day period following his Eligibility Date. The effective date of his participation will be the first day of the month following (1) the date the Participating Member School receives his completed enrollment form, or (2) the date he first became eligible, whichever is later.

By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

3.2 Termination of Participation. An individual who terminates employment with the Participating Member School shall be considered to have terminated participation in the Plan as of the individual's employment termination date, with the exception of submitting Dependent Care FSA claims as described in Section 6.4. The following rules shall apply to an individual who terminates employment with the Participating Member School:

- (a) The individual shall be ineligible to have additional Compensation Reductions used to purchase coverage under any School-sponsored Benefit Plans.
- (b) The individual shall be ineligible to receive any additional Compensation attributable to an election to waive coverage under a School-sponsored Benefit Plan. If the individual receives excess Compensation, the individual shall repay the excess amount to the Participating Member School.
- (c) The individual shall be ineligible to use any additional Compensation attributable to an election to waive coverage under a School-sponsored Benefit Plan toward the purchase of any Qualified Benefits.
- (d) The individual shall be ineligible to have additional amounts credited to his Flexible Spending Accounts. Amounts remaining in the individual's Health Care FSA may continue to be applied toward the reimbursement of claims for eligible expenses incurred before the date the individual's participation terminated. However, with respect to an individual's Health Care FSA, the individual shall not be eligible to be reimbursed for claims for eligible expenses incurred after the date his participation terminated, except to the extent the individual continues to participate in his Health Care FSA as described in Section 3.3.

3.3 Continuation Coverage. An individual whose participation in the Plan terminates has the option of continuing to participate in his Health Care FSA to the extent required by the continuation coverage provisions of COBRA. If the Participating Member School is subject to COBRA and if the amount of benefits remaining exceeds the cost of COBRA coverage, the Participant shall generally be eligible to continue to participate for the remaining portion of the Plan Year during which the individual's participation terminated. Continuation coverage is generally not available for a subsequent Plan Year unless, pursuant to U.S. Department of Treasury regulations, certain requirements are not met (e.g., benefits under the individual's Health Care FSA are not excepted benefits under HIPAA - See Section 5.8).

If an individual is eligible to elect COBRA with respect to his Health Care FSA, the individual may continue participation by making after-tax contributions on a monthly basis in an amount equal to 102% of the Compensation Reductions and any Participating Member School contribution or credit, if applicable, which were allocated to the individual's Health Care FSA each month before the date participation terminated. 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 shall be terminated if contributions are not made on a timely basis.

If an individual does not elect to continue to participate in his Health Care FSA under this Section or his participation is terminated for failing to timely make after-tax contributions, any amounts remaining in the individual's Health Care FSA after paying claims incurred while a Participant shall be forfeited.

3.4 Participation After Reemployment. A former Participant who is rehired within 30 days or less of the date of termination of employment will be reinstated with the same elections that such individual had before termination.

If a former Participant is rehired more than 30 days following termination of employment in the Plan Year in which he last was a Participant, he may make a new election regarding accident and health coverage and any group term life insurance coverage and make payment by Compensation Reductions; however, he may not re-enroll in the FSAs for that Plan Year.

3.5 Leave of Absence. Subject to any specific limitations for any particular benefit that the Employee has elected, and subject to the terms of Section 4.7 herein:

- (a) Participation will be continued during the leave of absence for which the Employee continues to receive a salary from the Participating Member School (provided Participants on non-FMLA paid leave are required to continue coverage); and
- (b) Participation during an unpaid leave of absence will cease (unless coverage is continued as provided in Sections 4.7 and 4.8 herein).

SECTION IV - BENEFITS

4.1 This Section Generally. This Section describes the benefit options that are available to a Participant under the Plan and the procedures for the Participant to make his elections. A Participant may make new choices for each Plan Year.

4.2 Benefit Options. A Participant may choose to receive one or more of the following benefits made available under the Plan.

(a) Contributions to the School-sponsored Benefit Plan(s) – Premium Payment.

The Participant may be required to pay all or part of the cost of coverage under the School-sponsored Benefit Plan(s). The Participant shall pay such cost with his Compensation Reductions. The Participating Member School shall inform the Participant of the applicable Compensation Reductions required to pay a Participant's cost of coverage. The cost of coverage may depend on certain factors such as the Participant's job classification or location, or whether coverage is elected for the Participant only or for the Participant and one or more of his Dependents.

(b) Health Care FSA.

A Participant may elect to have Compensation Reductions and/or any additional Compensation received upon the waiver of medical coverage under a School-sponsored Benefit Plan credited to his Health Care FSA.

(c) Dependent Care FSA.

A Participant may elect to have Compensation Reductions and/or any additional Compensation received upon the waiver of medical coverage under a School-sponsored Benefit Plan credited to his Dependent Care FSA.

(d) Cash in Lieu of Benefits.

A Participant may elect to waive coverage under a School-sponsored Benefit Plan. If permitted by the Participating Member School, a Participant may waive any such coverage. However, in order to waive medical coverage, the Participant must be required to have alternate medical coverage and provide sufficient evidence of that coverage to the Participating Member School, if required by the Participating Member School.

If a Participant elects to waive medical coverage, the Participant's Compensation may be increased by an amount (if any) determined by the Participating Member School for each Plan Year. The amount of any additional Compensation may vary depending on certain factors such as the Participant's job classification or location and the type of coverage waived by the Participant. The Participant may use/receive the additional Compensation as follows:

- (i) The Participant may choose to apply all or part of the additional Compensation to obtain Qualified Benefits, including any FSAs available under the Plan; and
- (ii) The Participant may choose to receive all or part of the additional Compensation through the Participating Member School's payroll system during the Plan Year to which the election relates. The additional Compensation shall be subject to all required tax withholdings. However, as provided in Section 3.2, a Participant shall not receive any additional Compensation on account of this election for any time period after he terminates employment with the Participating Member School.
- (iii) If participation under a School-sponsored Benefit Plan is waived for any person, and that person desires to be covered by the School-sponsored Benefit Plan at a later date, any applicable pre-existing condition provisions or other restrictions may apply.

4.3 Election of Benefits.

(a) Initial Election. Each Eligible Employee shall complete and return an enrollment form to the Participating Member School before the date the Employee becomes a Participant. If an Employee does not deliver a completed enrollment form to the Participating Member School before the Eligibility Date, the following rules shall apply for the Employee's initial Plan Year of participation:

- (i) With respect to coverage under the School-sponsored Benefit Plan(s) for which the Employee is eligible and is required to pay all or a part of the cost of coverage, the Employee shall be ineligible to pay for the coverage on a pre-tax basis under the Plan, unless his decision to participate is due to and consistent with a permissible change in accordance with Section 4.4.
- (ii) The Employee shall not receive additional Compensation for waiving medical coverage under the School-sponsored Benefit Plan(s), unless his decision to waive medical coverage is due to and consistent with a permissible change in accordance with Section 4.4.

- (iii) No amounts shall be credited to the Employee's FSAs , unless his decision to participate is due to and consistent with a permissible change in accordance with Section 4.4.
- (b) **Subsequent Elections.** Each Participant shall complete a new enrollment form for each subsequent Plan Year and deliver it to the Participating Member School during the Open Enrollment Period preceding that Plan Year. The new enrollment form shall be effective on the first day of the Plan Year to which it relates and remain in effect through the last day of that Plan Year, unless changed as provided in Section 4.4. If a Participant does not complete a new enrollment form and deliver it to the Participating Member School during the Open Enrollment Period, the following rules shall apply for the Employee's subsequent Plan Years of participation:
 - (i) With respect to coverage under the School-sponsored Benefit Plan(s) for which the Employee is eligible and is required to pay all or a part of the cost of coverage, the Employee shall be ineligible to pay for the coverage on a pre-tax basis under the Plan, unless his decision to participate is due to and consistent with a permissible change in accordance with Section 4.4.
 - (ii) No amounts shall be credited to the Employee's FSAs, unless his decision to participate is due to and consistent with a permissible change in accordance with Section 4.4.

4.4 Changes in Benefit Election During the Plan Year. Except as described in this Section 4.4, a Participant's election of benefits under the Plan, including the amount of any Compensation Reductions and participation under the Plan, is irrevocable and shall not be changed during a Plan Year, except as follows:

- (a) **Change in Status.** A Participant's election of benefits may be changed due to a “Change in Status,” in accordance with Section 4.5. (This subsection 4.4(a) applies to Pre-tax Premium Contributions, Health Care FSA and Dependent Care FSA benefits).
- (b) **FMLA.** A Participant's election may be changed if the Participant goes on an FMLA leave and changes his election in accordance with Section 4.7. (This subsection 4.4(b) applies to Pre-tax Premium Contributions and Health Care FSA benefits).
- (c) **Non-Discrimination Rules.** A Participant's election may be changed to satisfy any nondiscrimination rule in the Code, as described in Section 4.9. (This subsection 4.4(c) applies to Pre-tax Premium Contributions, Health Care FSA and Dependent Care FSA benefits).
- (d) **Change in Cost of Health Plan.** A Participant's Compensation Reductions shall be automatically changed, on a prospective and reasonable and consistent basis, to reflect any increase or decrease in the cost of coverage under the School-sponsored Benefit Plan(s) in which the Participant or the Participant’s Spouse or Dependent is enrolled. However, if the cost increase is significant, the Participant may either make a corresponding prospective increase in Compensation Reductions or alternatively, may revoke his election of coverage and receive prospective coverage under another health plan that provides similar coverage. (This subsection 4.4(d) applies to Pre-tax Premium Contributions only. This subsection does not apply to a Participant’s Health Care FSA benefits.)

- (e) **Change in Cost of Dependent Care.** A Participant's Compensation Reductions may be changed with respect to the Participant's Dependent Care FSA, on a prospective and reasonable and consistent basis, to reflect any increase or decrease in the cost of Dependent Care Services. However, this election change rule shall not apply if the dependent care provider is a relative as described in Section 152(a)(1) through (8) of the Code, incorporating the rules of Section 152(b)(1) and (2) of the Code. (This subsection 4.4(e) applies to Dependent Care FSA benefits only.)
- (f) **Change in Coverage.** A Participant's Compensation Reductions may be changed if coverage under any health plan in which the Participant or the Participant's Spouse or Dependent is enrolled is significantly curtailed or ceases. The Participant may elect to receive prospective coverage under another health plan that provides similar coverage. (This subsection 4.4(f) applies to Pre-tax Premium Contributions only. This subsection does not apply to a Participant's Health Care FSA benefit.)
- (g) **Addition or Significant Improvement of a Benefit Package Option.** If the Participating Member School offers a new benefit or coverage option or significantly improves an existing benefit or coverage option, the Participating Member School may permit the following election changes:
- (i) Participants who are enrolled in a benefit option other than the newly added or significantly improved benefit option may change their election on a prospective basis to elect the newly added or significantly improved benefit option; and
 - (ii) Employees who are otherwise eligible may elect the newly added or significantly improved benefit option on a prospective basis, subject to the terms and limitations of the benefit option.

(This subsection 4.4(g) applies to Pre-tax Premium Contributions and Dependent Care FSA benefits only. This subsection does not apply to a Participant's Health Care FSA benefit.)

- (h) **Change in Coverage Under Another Employer's Plan.** A Participant's election may be prospectively changed if it is on account of and corresponds with a change under the plan of the employer of the Participant's Spouse, former Spouse or Dependent ("Other Plan") where:
- (i) The Other Plan permits an election change that would be permitted under this Section; or
 - (ii) The Plan Year under this Plan is different from the plan year (for election purposes) under the Other Plan.

The Participant must certify to the Participating Member School that the Participant, Spouse or Dependent will obtain coverage under the Other Plan. (This subsection 4.4(h) applies to Pre-tax Premium Contributions only. This subsection does not apply to a Participant's Health Care FSA or Dependent Care FSA benefits.)

- (i) **HIPAA Special Enrollment Rights.** A Participant's election regarding health coverage may be changed in order to exercise special enrollment rights under HIPAA, even if the change in election would not be permitted under Section 4.5. Further, if the special enrollment rights situation is the addition of a new Dependent, a Participant's election to

enroll previously-existing Dependent children shall also be allowed. However, any retroactive enrollments for such changes shall be limited to birth, adoption, and placement for adoption. (This subsection 4.4(i) applies to Pre-tax Premium Contributions, but not to Health Care FSA or Dependent Care FSA benefits.)

- (j) **Certain Judgments, Decrees and Orders.** A Participant's election with respect to accident or health coverage may be changed because of a judgment, decree or order ("Order") resulting from divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires accident or health coverage (including an election for Health Care FSA benefits) for a Participant's child or for a foster child who is a Dependent of the Participant. Specifically, the Participant may:
- (i) Change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage), or
 - (ii) Change his or her election to cancel coverage for the Dependent child if the Order requires the Spouse, former Spouse or other individual to provide accident or health coverage for the child, and if the child actually becomes covered under the plan of the Spouse, former Spouse or other individual.

(This subsection 4.4(j) applies to Pre-tax Premium Contributions and Health Care FSA benefits, but not to Dependent Care FSA benefits.)

- (k) **Medicare and Medicaid.** If a Participant or a Participant's Spouse or Dependent becomes entitled to coverage under Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits), the Participant may prospectively elect to cancel or reduce the Participating Member School-provided accident or health coverage for the individual and/or the Participant's Health Care FSA coverage may be canceled or reduced. In addition, if a Participant or a Participant's Spouse or Dependent who has been entitled to coverage under Medicare or Medicaid (other than Medicaid coverage consisting solely of pediatric vaccine benefits) loses eligibility for such coverage, the Participant may elect to prospectively commence or increase the Participating Member School-provided accident or health coverage for the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health Care FSA coverage may commence or increase. (This subsection 4.4(k) applies to Pre-tax Premium Contributions, to Health Care FSA benefits as limited above, but not to Dependent Care FSA benefits.)

- (l) **Loss of Coverage Under Other Group Health Coverage.** If a Participant or a Participant's Spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, the Participant's election may be changed to add coverage for the Participant or Participant's Spouse or Dependent. (This subsection 4.4(l) applies to Pre-tax Premium Contributions and Dependent Care FSA benefits, but not to the Health Care FSA benefit.)

- (m) **Dependent Care FSA Coverage Changes.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example:

- (i) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and
- (ii) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

(This subsection 4.4(m) applies to Dependent Care FSA benefits only.)

- (n) **Open Enrollment.** A Participant may change an election during the Open Enrollment Period in accordance with Section 4.3. (This subsection 4.4(n) applies to Pre-tax Premium Contributions, Health Care FSA and Dependent Care FSA benefits.)

4.5 Change in Status. A Participant may make a new election upon the occurrence of certain events as described in Section 4.4, including a Change in Status, for the applicable component of the Plan. “Change in Status” means any of the events described below, as well as any other events included under subsequent changes to Code Section 125 or regulations issued thereunder, which the Plan Administrator in its sole discretion, on a uniform and consistent basis, determines are permitted under IRS regulations:

- (a) **Legal Marital Status.** An event that changes the Participant’s legal marital status, including marriage, death of the Participant’s Spouse, divorce, legal separation and annulment.
- (b) **Number of Dependents.** An event that changes the number of a Participant’s Dependents, including birth, adoption, placement for adoption and death of a Dependent.
- (c) **Employment Status.** An event affecting the employment status of the Participant or the Participant’s Spouse or Dependent, including a termination or 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 which affects an individual’s eligibility for benefits.
- (d) **Dependent Eligibility Requirements.** An event that causes a participant’s Dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, Student status, or any similar circumstance.
- (e) **Change in Residence.** A change in the place of residence of the Participant or the Participant’s Spouse or Dependent (as long as the move triggers eligibility or causes loss of eligibility under the group health plan, e.g., employee or Dependent moves outside HMO service area).

4.6 Consistency Requirement. If a Participant has a Change in Status under Section 4.5, a Participant may change his election under the Plan, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Participating Member School or a plan of the employer of the Participant’s Spouse or Dependent (referred to as the “general consistency requirement”). A Change in Status that affects eligibility for coverage under a plan of the Spouse’s or Dependent’s employer includes a Change in Status that results in an increase or decrease in the number of an Employee’s family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

The Plan Administrator in its sole discretion, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status.

- (a) **Loss of Dependent Eligibility.** For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Participating Member School's plan, the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation).
- (b) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.
- (c) **Special Consistency Rule for Dependent Care FSA Benefits.** With respect to Dependent Care FSA benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Qualifying Dependent Care Expenses for the tax exclusion under Code Section 129.
- (d) **Procedural Requirements.** A Participant who changes his benefit election on account of and consistent with, a Change in Status, must submit a "Change in Benefit Election" form to the Plan Administrator no later than 30 days after the Change in Status occurs. Any new election under this Section shall be effective at the time prescribed by the Plan Administrator. Further, any new election involving an independent, third-party provider shall only be approved to the extent permitted by the independent, third-party provider.

4.7 FMLA Leaves of Absence. Notwithstanding any other provision of the Plan, if the Participating Member School is subject to FMLA, the following rules apply to a Participant who takes a FMLA leave.

- (a) *Health Benefits.* Notwithstanding any other provision of the Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Participating Member School will continue to maintain the Participant's health insurance benefits and Health FSA benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Participating Member School will continue to pay its share of the premium.

In the event of unpaid FMLA leave, a Participant may elect to continue his or her health insurance benefits and/or Health FSA benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant must pay his or her share of the premium in one of the following ways:

- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any, including unused sick days and vacation days), or pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);
- with after-tax dollars, by sending monthly payments to the Participating Member School by the due date established by the Participating Member School; or
- under another arrangement agreed upon by the Participant and the Participating Member School (e.g., the Participating Member School may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation upon the Participant's return on a pre-tax or after-tax basis).

If the Participating Member School requires all Participants to continue health insurance benefits and Health FSA benefits during an unpaid FSA leave, the Participant may elect to discontinue payment of the Participant's required premiums until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Participating Member School and the Participant.

If a Participant's health insurance benefits or Health FSA benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), the Participant is entitled to re-enter the Pre-tax Premium Contribution benefit and/or Health FSA benefit, as applicable, upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. Participants whose health insurance benefits or Health FSA benefits coverage terminated during the leave are entitled to be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

Notwithstanding the preceding sentence, with regard to Health FSA benefits, the Participant whose coverage ceased will be entitled to elect whether to be reinstated in the Health FSA benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of the FMLA leave during which the Participant did not pay premiums. If a Participant elects a coverage level that is reduced pro-rata for the

period of FMLA leave, the amount withheld from a Participant's Compensation on a payroll-by-payroll basis for the purposes of paying for reinstated Health FSA coverage will be equal to the amount withheld prior to the period of FMLA leave. Under either option, claims incurred during the leave period when coverage was terminated cannot be reimbursed.

- (b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits, such as Dependent Care FSA benefits, is to be determined by the Participating Member School's policy for providing such benefits when the Participant is on non-FMLA leave, as described in Section 4.8. If such policy permits a Participant to discontinue contributions while on leave, the Participant will upon returning from leave be required to repay the premiums not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Participating Member School and the Participant, or as the Participating Member School otherwise deems appropriate.

4.8 Non-FMLA Leaves of Absence. If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be pre-paid before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Participating Member School.

If a Participant goes on an unpaid leave of absence that affects eligibility, and to the extent COBRA applies, the Participant may continue coverage under COBRA.

4.9 Nondiscrimination Rules. For each Plan Year, the following nondiscrimination rules shall be satisfied:

- (a) The Plan shall be made available to a nondiscriminatory classification of Employees, as described in Section 410(b)(2)(A)(i) of the Code;
- (b) The Plan shall not discriminate in favor of Highly Compensated Individuals with regard to contributions or benefits, except as permitted under Section 125 of the Code; and
- (c) The nontaxable benefits provided to Key Employees shall not exceed 25% of the aggregate nontaxable benefits provided to all Participants in the Plan.

If the Plan Administrator determines at any time that the Plan may not satisfy the non-discrimination rules in the Code, the Plan Administrator and Participating Member School may take whatever action it considers appropriate to assure compliance with the rules. Any action shall be taken uniformly with respect to similarly situated Participants. The action may include the modification of Participants' elections, with or without the consent of the Participants.

4.10 Maximum Compensation Reductions and Maximum Employer Contributions. Subject to Section 4.9, a Participant's maximum Compensation Reductions in a Plan Year shall be the sum of the following:

- (a) The Participant's Compensation Reductions to pay required contributions for the most expansive coverage available to the Participant under any School-sponsored Benefit Plan(s).

- (b) The maximum Compensation Reductions permitted to a Participant's Health Care FSA under Section 5.2.
- (c) The maximum Compensation Reductions permitted to a Participant's Dependent Care FSA under Section 6.2.

Subject to Section 4.9, a Participant's maximum employer contribution for a Plan Year shall be the additional Compensation which the Participating Member School may pay to the Participant for waiving any medical coverage for which he is eligible under a School-sponsored Benefit Plan(s).

SECTION V - HEALTH CARE FSA

5.1 Establishment of Health Care FSA. CSI shall establish and maintain a Health Care FSA for each Participant who elects to receive reimbursement for Qualifying Health Care Expenses in a manner that is excludable from gross income under Section 105(b) of the Code. The Health Care FSA portion of the Plan is intended to qualify as a medical reimbursement plan under Section 105(h) of the Code and is interpreted in a manner consistent with the requirements of Section 105(h) of the Code. Further, the Health Care FSA portion of the Plan shall be considered a "separate" plan to the extent required by the Code and U.S. Department of Treasury regulations. The Health Care FSA so established shall be merely a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 5.6.

5.2 Crediting of Health Care FSA. For each Plan Year, pursuant to Sections 4.2(b) and 4.3, a Participant may allocate up to \$2,500 to the Participant's Health Care FSA for the reimbursement of Qualifying Health Care Expenses under the Plan. The election shall be made by the Participant on the enrollment form. The amount allocated for each Participant under this Section shall be credited to the Participant's Health Care FSA.

If, during a Plan Year, a Participant increases his Health Care FSA allocation for the Plan Year pursuant to Section 4.4, the Participant shall be entitled to be reimbursed for Qualifying Health Care Expenses incurred at any time during the Plan Year, up to the higher amount.

5.3 Covered Expenses. Amounts credited to a Participant's Health Care FSA shall be used to reimburse the Participant for Qualifying Health Care Expenses.

5.4 Reimbursement of Qualifying Health Care Expenses. Benefits from a Participant's Health Care FSA for each Plan Year shall be paid only for Qualifying Health Care Expenses incurred during that Plan Year. For purposes of this Section, a Qualifying Health Care Expense shall be incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the medical care. All claims for reimbursement must be filed no later than 90 days after the end of the Plan Year.

Participants shall be entitled to uniform coverage under their Health Care FSA throughout the Plan Year. A Participant shall be entitled to reimbursement for claims incurred at any time throughout the Plan Year, regardless of the balance in the Participant's Health Care FSA. However, claims shall not be reimbursed to the extent they exceed the amounts a Participant has allocated under Section 5.2 to his Health Care FSA for the Plan Year.

Claims shall be paid as soon as administratively feasible after the claim is received by the Plan Administrator (or the Benefit Administrator, if one is appointed), but in no event less frequently than monthly.

5.5 Claims for Reimbursement. A Participant shall request reimbursement, in writing, on a form provided by the Plan Administrator. The form shall include the following information:

- (a) The amount, date and nature of the Qualifying Health Care Expense for which reimbursement is requested;
- (b) The name and address of the person or entity to which the Qualifying Health Care Expense was paid;
- (c) The name of the person for whom the Qualifying Health Care Expense was incurred, and the person's relationship to the Participant;
- (d) The amount recovered or expected to be recovered under any insurance arrangement or other source; and
- (e) A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Any insurance Explanation of Benefits (EOBs) or itemized statements or receipts documenting the Qualifying Health Care Expenses shall accompany the form. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator (or the Benefit Administrator) shall verify each claim for reimbursement and determine whether the claim is for Qualifying Health Care Expenses. All reimbursement checks shall be made payable to the Participant. The Plan shall not recognize an assignment of benefits. For reimbursement claims that are denied, see the appeals procedure in Section 8.4.

5.6 Forfeiture of Health Care FSA. If any balance remains in a Participant's Health Care FSA for a Plan Year after all eligible reimbursements have been made, the balance shall be forfeited by the Participant. The balance shall not be carried over to reimburse the Participant for Qualifying Health Care Expenses incurred during a subsequent Plan Year.

5.7 Special Nondiscrimination Rule. In addition to the nondiscrimination rules described in Section 4.9, the Health Care FSA shall also be subject to the applicable nondiscrimination requirements under Section 105(h) of the Code. Section 105(h) of the Code prohibits discrimination in eligibility or benefits in favor of Highly Compensated Individuals (as that term is defined in Section 105(h) of the Code).

5.8 HIPAA. For each Plan Year, a Participant's Health Care FSA shall be considered an excepted benefit that is not subject to HIPAA if all three of the following requirements are satisfied:

- (a) The maximum benefit payable by the Participating Member School (if any) under the Health Care FSA for the Plan Year does not exceed two times the Participant's Compensation Reduction election under the Health Care FSA for the Plan Year (or, if greater, the amount of the Participant's Compensation Reduction election under the Health Care FSA for the Plan Year plus \$500);
- (b) The Participant is eligible for the School-sponsored Benefit Plan(s) other than the Health Care FSA for the Plan Year; and

- (c) The other School-sponsored Benefit Plan(s) are not limited to benefits that are excepted benefits under HIPAA.

If a Participant's Health Care FSA does not qualify as an excepted benefit for a Plan Year, the Plan shall comply with HIPAA with respect to the Participant's Health Care FSA for the Plan Year (e.g., by granting special enrollment rights regarding the Health Care FSA and by issuing any required Certificates of Creditable Coverage upon termination of participation.)

5.9 Compliance with ERISA and Laws Applicable to Group Health Plans

- (a) **Named Fiduciary.** CSI is the named fiduciary for the Health Care FSA benefit for purposes of ERISA Section 402(a).
- (b) **Laws Applicable to Group Health Plans.** Health FSA benefits shall be provided in compliance with the following laws to the extent that such laws are applicable to the Health Care FSA (and the Health Care FSA is not otherwise exempt or excepted from their terms):
- ERISA, including Section 609(a) relating to group health plan coverage pursuant to medical child support orders, and Section 609(b) relating to the rights of states with respect to group health plans where participants or beneficiaries are eligible for medicaid benefits;
 - COBRA;
 - HIPAA;
 - FMLA;
 - Mental Health Parity Act of 1996, as amended;
 - Newborns' and Mothers' Health Protection Act of 1996, as amended;
 - Women's Health and Cancer Rights Act of 1998, as amended;
 - Uniformed Services Employment and Reemployment Rights Act of 1994, as amended; and
 - Medicare Secondary Payer law, as amended.
- (c) **Coordination of Benefits.** Health Care FSA Benefits are intended to pay benefits solely for medical care expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health Care FSA shall not be considered a group health plan for coordination of benefits purposes, and Health Care FSA benefits shall not be taken into account when determining benefits payable under any other plan.

SECTION VI - DEPENDENT CARE FSA

- 6.1 **Establishment of Dependent Care FSA.** The Participating Member School shall establish and maintain a Dependent Care FSA for each Participant who elects to receive reimbursement for Qualifying Dependent Care Expenses in a manner that is excludable from gross income under Section 129 of the Code. The Dependent Care FSA portion of the Plan is intended to qualify as a dependent care assistance plan under Section 129 of the Code and is to be interpreted in a manner consistent with the requirements of Section 129 of the Code. Further, the Dependent Care FSA portion of the Plan shall be considered a "separate" plan to the extent required by the Code and the U.S. Department of Treasury regulations. The Dependent Care FSA so established shall be merely a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 6.9.

6.2 Crediting of Dependent Care FSA. For each Plan Year, pursuant to Sections 4.2(c) and 4.3, a Participant may allocate an amount to the Participant's Dependent Care FSA for the reimbursement of Qualifying Dependent Care Expenses under the Plan. The allocation shall be made by the Participant in his enrollment form. The amount allocated shall be subject to the limitations described in this Section and shall be credited to the Participant's Dependent Care FSA.

The maximum amount which may be credited to a Participant's Dependent Care FSA during a calendar year shall be the lesser of the following amounts:

- (a) \$5,000 (\$2,500 in the case of a married Participant filing a separate income tax return); or
- (b) An amount equal to the Participant's Earned Income for the calendar year or, if the Participant is married on the last day of the calendar year, the lesser of the Earned Income of the Participant or his Spouse. For purposes of this subsection, a Spouse who is a Student or is either physically or mentally incapable of self-care during any month in which the Participant incurs Qualifying Dependent Care Expenses shall be deemed to have the following Earned Income for the month:
 - (i) \$200, if there is one Qualifying Individual for whom the Participant incurs Qualifying Dependent Care Expenses; or
 - (iii) \$400, if there is more than one Qualifying Individual for whom the Participant incurs Qualifying Dependent Care Expenses.

For tax years beginning on January 1, 2003, these amounts shall increase to \$250 and \$500 respectively.

6.3 Covered Expenses. Amounts credited to a Participant's Dependent Care FSA shall be used to reimburse the Participant for Qualifying Dependent Care Expenses.

6.4 Reimbursement of Qualifying Dependent Care Expenses. Benefits from a Participant's Dependent Care FSA for each Plan Year shall be paid only for Qualifying Dependent Care Expenses incurred during that Plan Year. For purposes of this Section, a Dependent Care Expense is incurred at the time the Dependent Care FSA giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the Dependent Care FSA. However, if a Participant terminates employment with the Participating Member School, the Participant may submit all claims for reimbursement incurred after their date of termination, but before the end of the Plan Year, as long as they are employment related. All claims for reimbursement must be filed no later than 90 days after the end of the Plan Year.

Claims shall be paid only to the extent of the balance in the Participant's Dependent Care FSA at the time the claim is filed based on the year-to-date amount that has been withheld from the Participant's Compensation for reimbursement for Qualifying Dependent Care Expenses for the Period of Coverage, less any prior reimbursements for Qualifying Dependent Care Expenses during the Period of Coverage. If the balance in the Dependent Care FSA is insufficient to pay a claim in full, the unpaid balance of the claim shall be carried over and paid when and if a sufficient amount is credited to the Dependent Care FSA later in the Plan Year.

Claims shall be paid as soon as administratively feasible after the claim is received by the Plan Administrator (or the Benefit Administrator, if one is appointed), but in no event less frequently than monthly.

6.5 No Reimbursement for Amounts Paid to Related Individuals. The Plan shall not reimburse a Participant for a Dependent Care Expense owed to the following individuals:

- (a) A Dependent of the Participant;
- (b) The Spouse of the Participant; or
- (c) A child of the Participant if the child was under the age of 19 on the last day of the Participant's taxable year during which the Dependent Care Expense was incurred.

6.6 Claims for Reimbursement. A Participant shall request reimbursement, in writing, on a form provided by the Plan Administrator. The form shall include the following information:

- (a) The amount, date and nature of the Dependent Care Expense for which reimbursement is requested;
- (b) The name of the person or entity to which the Dependent Care Expense was paid;
- (c) The name of the person for whom the Dependent Care Expense was incurred, and the person's relationship to the Participant;
- (d) The amount recovered or expected to be recovered under any other source; and
- (e) A statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Any itemized statements or receipts documenting the Qualifying Dependent Care Expenses shall accompany the form. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator (or the Benefit Administrator) shall verify each claim for reimbursement and determine whether the claim is for Qualifying Dependent Care Expenses. All reimbursement checks shall be made payable to the Participant. The Plan shall not pay benefits to the dependent care provider and shall not recognize an assignment of benefits. For reimbursement claims that are denied, see the appeals procedure in Section 8.4.

6.7 Dependent Care Certification Statement. Each Plan Year, a Participant requesting reimbursement under the Plan must submit to CSI a statement containing the following information, as a condition precedent to such reimbursement:

- (a) The name, address and taxpayer identification number of the person or entity to which the Dependent Care Expense will be paid;
- (b) The Dependent or Dependents for which the services are being performed, and the age and relationship of such Dependent or Dependents;
- (c) The relationship, if any, of the person performing the services for the Participant;
- (d) If the services are being performed by a child of the Participant, the age of such child;
- (e) A statement as to where the services are being performed;

- (f) If the services are being performed in a dependent care center (as defined in Section 21(b) of the Code), a statement indicating that the dependent care center provides care for more than six individuals and complies with all applicable state and local laws and regulations; and
- (g) A statement that (if the Participant is married) the Participant's Spouse's annual Earned Income exceeds the amount of Qualifying Dependent Care Expenses elected, and whether the Participant's Spouse is a Student or is either physically or mentally incapable of self-care.

6.8 Statement of Expenses. On or before each January 31, the Participating Member School shall provide each Participant with a written statement of the amounts reimbursed under the Plan for Qualifying Dependent Care Expenses incurred during the preceding calendar year and/or the amounts allocated to the Participant's Dependent Care FSA for the preceding calendar year, by including such amounts in the appropriate box reporting dependent care benefits on Form W-2.

6.9 Forfeiture of Dependent Care FSA. If any balance remains in a Participant's Dependent Care FSA for a Plan Year after all eligible reimbursements have been made, the balance shall be forfeited by the Participant. The balance shall not be carried over to reimburse the Participant for Qualifying Dependent Care Expenses incurred during a subsequent Plan Year.

6.10 Special Nondiscrimination Rules. In addition to the nondiscrimination rules described in Section 4.9, the Dependent Care Spending Plan shall also be subject to the applicable nondiscrimination requirements under Section 129(d) of the Code, which are described in this Section.

- (a) **Contributions or Benefits.** The contributions or benefits provided under the Dependent Care Spending Plan shall not discriminate in favor of Highly Compensated Employees or their Dependents.
- (b) **Eligibility.** The Dependent Care FSA shall benefit Employees who qualify under a classification set up by the Participating Member School which does not discriminate in favor of Highly Compensated Employees or their Dependents. Any Employees who have not attained age 21 and completed one year of continuous employment may be excluded for purposes of this nondiscrimination test, to the extent permitted under Section 129(d)(9)(A) of the Code.
- (c) **Principal Shareholders or Owners.** Not more than 25% of the amounts paid or incurred by the Participating Member School for dependent care assistance during the year may be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the year) owns more than 5% of the stock or of the capital or profits interest in the Participating Member School.
- (d) **55% Average Benefits Test.** The average dependent care benefits provided to the Participants who are not Highly Compensated Employees under all of the Participating Member School's dependent care assistance plans must be at least 55% of the average dependent care benefits provided to all Participants who are Highly Compensated Employees under all of the Participating Member School's dependent care assistance plans, as provided under Section 129(d)(8) of the Code.

Any Employees with annual Compensation of less than \$25,000 may either be included or excluded for purposes of the 55% average benefits test. Further, any Employees who have not attained age 21 and completed one year of continuous employment may be excluded for purposes of the 55% average benefits test, to the extent permitted under Section 129(d)(9)(A) of the Code.

Plan Sponsor shall conduct periodic testing immediately before and/or during each Plan Year to determine if the 55% average benefits test is being satisfied. As of the first date during a Plan Year, if Plan Sponsor's testing indicates that the 55% average benefits test shall not be satisfied, the amounts allocated to the Dependent Care FSAs on behalf of Participants who are Highly Compensated Employees may be reduced to the extent necessary to satisfy the 55% average benefits test and/or all or a portion of the amounts allocated to the Dependent Care FSAs on behalf of the Participants who are Highly Compensated Employees may be treated as taxable income.

SECTION VII - FUNDING

7.1 Funding of Benefits. All benefits provided under the Plan shall be paid from the Participating Member School's general assets. The FSAs shall be for bookkeeping purposes only. Nothing herein shall be construed to require the Participating Member School or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Participating Member School or the Plan Administrator from which any payment under this Plan may be made.

SECTION VIII - ADMINISTRATION

8.1 Plan Administrator and Named Fiduciary. CSI is the Plan Administrator and named fiduciary of the Plan as those terms are defined in ERISA.

8.2 Powers of Plan Administrator. The Plan Administrator shall have the discretionary authority and power necessary to administer and meet its obligations under the Plan, including, without limitation, the following:

- (a) Interpret the terms and provisions of the Plan.
- (b) Decide all questions of eligibility for participation in the Plan.
- (c) Decide all questions of eligibility for benefit payments and determine the amount and manner of the payment of benefits.
- (d) Make and enforce rules and regulations it deems necessary for the efficient administration of the Plan.
- (e) Pay contributions and premiums under the Plan in a timely manner for all Participants entitled to payment under the Plan and pay expenses incident to the administration of the Plan.
- (f) Establish procedures by which Participants may apply for reimbursement under the Plan.
- (g) Determine the rights under the Plan of any Participant applying for or receiving reimbursement.

- (h) Reimburse all Participants entitled to reimbursement under the Plan in a timely manner.
- (i) Administer the appeal procedure provided in this Section.
- (j) Perform all acts necessary to meet the reporting and disclosure obligations imposed by Sections 101 through 111 of ERISA.
- (k) Delegate specific responsibilities for the operation and administration of the Plan to any Employees or agents.
- (l) Maintain records and accounts pertaining to the Plan.

8.3 Administrative Services. The Plan Administrator may enter into an administration agreement with a Benefit Administrator, under which the Benefit Administrator shall be given broad authority by the Plan Administrator to administer claims for reimbursement under the Plan and to render other administrative services on behalf of the Plan. The Benefit Administrator shall review, interpret, and evaluate all claims for reimbursement under the Plan. However, the Benefit Administrator shall have no power to modify any terms of the Plan or any benefit provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. The Plan Administrator shall have the sole and final discretion regarding whether any expense is eligible for reimbursement under the Plan.

To the extent that these administrative responsibilities are assumed by the Benefit Administrator under an administration agreement, the Participating Member School and the Plan Administrator shall have no responsibility for these functions.

8.4 Appeal Procedure. If a claim for reimbursement under this Plan is wholly or partly denied, claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. The Plan Administrator may appoint a committee to act on behalf of the Plan Administrator with respect to appeals.

Claims and reimbursement for insurance benefits shall be administered in accordance with the claims procedures for the applicable insurance benefit, as set forth in the insurance plan documents and/or summary plan description for the applicable insurance plans.

8.5 Standard of Care. The Plan Administrator shall administer the Plan in accordance with the terms of the Plan solely in the interest of the Participants and for the exclusive purposes of providing benefits to Participants and defraying the reasonable expenses of administration of the Plan. The Plan Administrator shall administer the Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this Section. The Plan Administrator shall not be liable for any act or omission by another relating to the Plan.

8.6 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such a person, then such payment otherwise due to such Participant or

other person shall be forfeited following a reasonable time after the date any such payment first became due.

- 8.7 Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Participating Member School from Compensation paid by the Participating Member School.

SECTION IX - RIGHTS OF PARTICIPANTS

- 9.1 Employment Rights.** The existence of the Plan shall not grant a Participant any legal right to continue as an Employee, or affect the right of the Participating Member School to discharge a Participant.
- 9.2 Participants' Rights.** The Plan shall be maintained for the exclusive benefit of the Participants and their Dependents. However, the existence of the Plan shall not give any Participant or Dependent any equity or other interest in the assets, business or affairs of the Participating Member School or CSI. Similarly, the existence of the Plan does not give any Participant or Dependent the right to challenge any action taken by the Participating Member School or CSI, or any policy adopted or followed by the Participating Member School or CSI, or the right to examine any of the books and records of the Participating Member School or CSI.
- 9.3 Spendthrift Provision.** No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest shall be void. No interest shall be liable for or subject to the debts or liabilities of any Participant.

SECTION X – ADOPTION BY PARTICIPATING MEMBER SCHOOLS

- 10.1 Adopting Participating Member Schools.** With the approval of CSI, any Member School may adopt the Plan for the benefit of its Eligible Employees. Adoption shall be accomplished by having the Member School execute a participation agreement and adding the name of the Participating Member School and the effective date of adoption to Appendix A of the Plan.

SECTION XI - PLAN AMENDMENT AND TERMINATION

- 11.1 Amendment of Plan.** The Plan Administrator reserves the right to amend the Plan, in whole or in part, at any time, provided that any Amendment meets the requirements of Section 11.3.
- 11.2 Termination of Plan.** The Plan Administrator reserves the right to terminate or partially terminate the Plan at any time, provided that any termination meets the requirements of Section 11.3.
- 11.3 Limitations on Amendment or Termination.** Any amendment or termination of the Plan is subject to the following:
- (a) No amendment or termination shall reduce or eliminate a Participant's right to have his required contribution under a School-sponsored Benefit Plan paid in accordance with the

provisions of the Plan to the extent a Participant has made Compensation Reductions to pay the required contributions.

- (b) No amendment or termination shall reduce or eliminate a Participant's right to have any additional Compensation paid or used to obtain Qualified Benefits in accordance with the provisions of the Plan to the extent the additional Compensation is attributable to medical coverage waived prior to the date of the amendment or termination.
- (c) No amendment or termination shall reduce or eliminate a Participant's right to claim reimbursement in accordance with the provisions of the Plan to the extent there are amounts credited to the Participant's FSAs as of the date of the amendment or termination and to the extent the expense was incurred prior to the date of the amendment or termination.
- (d) Any amendment or termination shall be in writing. The terms of the Plan shall not be modified by any oral statements made by Participating Member School or CSI, or any of their directors, officers, employees, agents or authorized representatives, including, but not limited to, the Benefit Administrator.

Any Amendment may be made retroactively to the extent permitted by the Code.

SECTION XII - MISCELLANEOUS PROVISIONS

- 12.1 Age.** Any reference in the Plan to age shall mean the age of the individual as of the individual's last birthday.
- 12.2 Uniformity of Treatment.** Any action taken under the Plan by the Plan Administrator or the Participating Member School shall be uniform in its application to similarly situated persons.
- 12.3 Effect Upon Other Compensation-Related Plans.** Participation in the Plan is not intended to affect any other Compensation-related employee benefit plan maintained or sponsored by the Participating Member School. Any contributions or benefits under any other Compensation-related employee benefit plan with respect to a Participant shall, to the extent permitted by law and not otherwise provided for in the other plan, include any amounts by which the Participant's Compensation is reduced pursuant to the provisions of the Plan.
- 12.4 Construction.** Words used in the masculine shall apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural shall be read as the singular and the singular as the plural.
- 12.5 Governing Law.** To the extent that Michigan law is not preempted by ERISA, the provisions of the Plan shall be governed by the laws of the state of Michigan.
- 12.6 ERISA.** To the extent that the Plan is subject to ERISA, it is intended that the Plan qualify in every aspect with the mandatory provisions of ERISA relating to welfare benefit plans. The provisions of the Plan shall be construed accordingly.

In executing this document, the undersigned, on behalf of the Trustees of CSI, acknowledges that this Plan is a complicated legal document which should not be adopted without the advice of an attorney. The undersigned, on behalf of the Trustees of CSI, further acknowledges that they have sought any legal advice it deemed necessary, including legal advice as to the tax and labor law consequences of adopting this Plan.

CHRISTIAN SCHOOLS INTERNATIONAL

By _____
(*Duly Authorized Representative*)

Its _____

Date _____

**APPENDIX A
to the**

CSI FLEXIBLE BENEFITS PLAN

The Eligible Employees of the following Participating Member Schools are eligible to participate in the Plan as of the dates indicated:

<u>Participating Member School and School Number</u>	<u>Participation Effective Date</u>
Ada Christian School (201)	September 1, 2002
Anderson Christian School (1336)	September 1, 2002
Bellflower Christian Schools (810)	September 1, 2002
Bradenton Christian School (903)	September 1, 2002
Calvin Christian School (819)	September 1, 2002
Calvin Christian School (671)	September 1, 2002
Calvin Christian School (653)	September 1, 2002
Calvin Christian School (327)	September 1, 2002
Celeryville Christian School (337)	October 1, 2002
Central Wisconsin Christian Schools (419)	September 1, 2002
Chandler Christian School (639)	September 1, 2002
Chattanooga Christian School (1340)	September 1, 2002
Christian Learning Center (228)	September 1, 2002
Christian School International (1403)	September 1, 2002
Crown Point Christian School (324)	September 1, 2002
Cutlerville Christian School (227)	September 1, 2002
Delavan Christian School (401)	September 1, 2002
DeMotte Christian School (330)	September 1, 2002
Dutton Christian School (209)	September 1, 2002
East Martin Christian Elementary School (286)	September 1, 2002
Eastern Christian School (124)	September 1, 2002
El Montecito Early School (814)	September 1, 2002
Everett Christian School (707)	September 1, 2002
Flushing Christian School (148)	September 1, 2002
Freedom Baptist School (274)	September 1, 2002
Grand Haven Christian School (221)	September 1, 2002
Grand Rapids Baptist School (229)	September 1, 2002
Grandville Christian School (261)	September 1, 2002
Highland Christian School (331)	September 1, 2002
Holland Christian School (268)	September 1, 2002
Hudsonville Christian School (279)	September 1, 2002
Jenison Christian School (282)	September 1, 2002
Kelloggsville Christian School (235)	September 1, 2002
LaFayette Christian School (333)	September 1, 2002
LakeWorth Christian School (907)	September 1, 2002
Lansing Christian School (271)	September 1, 2002
Lansing Christian School (321)	September 1, 2002
Milwaukee Christian School (405)	September 1, 2002
Moline Christian School (287)	September 1, 2002

Participating Member School and School Number**Participation Effective Date**

Muskegon Christian Schools (288)	September 1, 2002
Netherlands Reformed Christian School (137)	September 1, 2002
Newton Christian Day School (503)	September 1, 2002
Oak Harbor Christian School (719)	September 1, 2002
Oakwood Christian Nursery School (208)	September 1, 2002
Ontario Christian Schools (826)	September 1, 2002
Oostburg Christian Schools (407)	September 1, 2002
Pella Christian Grade School (507)	September 1, 2002
Pella Christian High School (509)	September 1, 2002
Phil-Mont Christian Academy (167)	September 1, 2002
Phoenix Christian School (801)	September 1, 2002
Potter's House (242)	September 1, 2002
Protestant Reformed Christian School (329)	September 1, 2002
Racine Christian School (409)	September 1, 2002
Redlands Christian School (829)	September 1, 2002
Rehoboth Christian School (830)	September 1, 2002
Ripon Christian School (831)	September 1, 2002
Rochester Christian School (149)	September 1, 2002
Roseland Christian School (309)	September 1, 2002
San Jose Christian School (833)	September 1, 2002
Sheboygan Christian School (415)	September 1, 2002
Sheboygan Co. Christian High (416)	September 1, 2002
Shoreline Christian School (721)	September 1, 2002
South Christian High School (245)	September 1, 2002
Sully Christian School (515)	September 1, 2002
Sunnyside Christian School (725)	September 1, 2002
Sutton Christian School (663)	September 1, 2002
Timothy Christian School (517)	September 1, 2002
Twin Oaks Christian School (335)	September 1, 2002
Unity Christian High School (280)	September 1, 2002
Washington Christian Academy (113)	September 1, 2002
West Sayville Christian School (151)	September 1, 2002
West Side Christian School (257)	September 1, 2002
Western Michigan Christian High School (289)	September 1, 2002
Westminster Theological Seminary (809)	September 1, 2002
Zeeland Christian School (297)	September 1, 2002