



**CHRISTIAN SCHOOLS
INTERNATIONAL**

**Summary Plan Description
of the
CSI FLEXIBLE BENEFITS PLAN**

Introduction

Your Board has adopted the CSI Flexible Benefits Plan to give you an opportunity to take advantage of certain non-taxable benefits which can help you better meet your personal and financial goals.

This document is called a "Summary Plan Description." The document uses a question and answer format to explain the provisions of the Flexible Benefits Plan ("Plan") and how it works. The Plan qualifies as a "cafeteria plan" under Section 125 of the Internal Revenue Code, and allows you to tailor your benefits to meet your individual needs from year to year.

You are urged to read this Summary Plan Description carefully and to keep a copy for future reference. Although every effort has been made to describe the Plan accurately in this document, the provisions of the Plan are fully detailed in the Plan Document which serves as the final authority in resolving questions or controversy. You may review a copy of the Plan Document in the school office during regular business hours, or you may request a copy in writing for which a reasonable charge may be made.

In the event of any difference between the Summary Plan Description and the Plan Document, the terms of the Plan Document will control.

The existence of the Plan does not grant you any legal right to continue employment with the School, or affect the School's right to discharge you.

If you have any questions about your benefits under the Plan, please contact the School office.

Q.1 What is the Flexible Benefits Plan?

The Flexible Benefits Plan is a Plan which allows you to design a benefits package to suit the individual needs of you and your family. You have the following benefit choices under the Plan:

- You may elect to pay your portion of the premium for our School-sponsored Benefit Plan(s) on a pre-tax basis.
- You may elect to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying health care expenses.
- You may elect to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying dependent care expenses.
- If provided by your School and if you have other medical coverage (for example, through your Spouse's employer), you may waive our School-provided medical coverage and receive additional Compensation. You must provide proof of the other medical coverage to the School (i.e., photocopy of health insurance identification card).

More information regarding the types of tax-free benefits that you may choose and the procedures for making your benefit elections are explained in the following sections of this Summary Plan Description. Although the Plan is intended to comply with the Internal Revenue Code's provisions for Flexible Benefits Plans, Christian Schools International and your Participating Member School do not guarantee this or any other tax consequences.

References are made throughout this Summary Plan Description to the "Plan Year." The Plan Year is the 12-month accounting period for the Plan that begins on September 1 and ends on August 31.

Q.2 What are the advantages of participating in the Plan?

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will need coverage under our School-sponsored Benefit Plan(s), or will incur an expense that may be reimbursed through your Flexible Spending Accounts (FSAs), you could reduce your pay and obtain the coverage or pay the reimbursable expense with "pre-tax" income rather than "after-tax" income.

The only disadvantage is that the pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits. Any loss in Social Security benefits can usually be offset easily by directing a portion of your tax savings to a personal or School-sponsored savings or retirement plan.

Other advantages include:

- *Personalized Benefits* – The Plan benefit suits you because you create a Plan that specifically meets the needs of you and your family.
- *Increased Spendable Income*—By contributing pre-tax dollars, you reduce the amount of your income subject to payroll taxes. So, if you were already paying for eligible expenses with after-tax dollars, you may stretch your buying power further.
- *Convenient Payroll Deduction*—The amount you elect to contribute will automatically be deducted in equal amounts from your paycheck throughout the Plan Year.

Q.3 What are my benefit choices under the Plan?

For each Plan Year, you may choose from the following benefits:

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

The School maintains and sponsors one or more group insurance plans that provide you and your Dependents with various health coverage options. You may be required to pay a portion of the cost of this coverage if you decide to elect coverage. This amount can be automatically deducted from your paycheck on a pre-tax basis.

Health Care Flexible Spending Account (FSA)

You may use your pay reductions to obtain reimbursement of qualifying health care expenses incurred by you and your family. This includes reimbursement of most medical, dental, vision or hearing expenses not covered by the School-sponsored Benefit Plan(s), or your Spouse's health plan.

Dependent Care Flexible Spending Account (FSA)

You may use your pay reductions to obtain reimbursement of qualifying Dependent care expenses incurred for the care of a Dependent child or adult who is your IRS Dependent, to enable you and, if married, your Spouse to work.

Cash in Lieu of Benefits.

If offered by the Participating Member School, you may elect to waive coverage under the School-sponsored Benefit Plan(s) and increase the amount of your salary. However, you may only waive medical coverage for yourself and your Dependents if permitted by your Participating Member School, and if you have other medical coverage (for example, from your Spouse's employer). If medical coverage is waived, your School may pay additional Compensation to you which you may elect to have credited to your FSAs or alternatively, may receive in your paychecks during the Plan Year for which the medical coverage was waived.

Q.4 Who is eligible to enroll in the Plan?

Educational employees who regularly work at least 500 classroom hours per Plan Year, and all other employees who regularly work at least 20 hours per week are eligible to enroll in the Plan. You are eligible to participate on the first day of the month coincident with or following your date of employment with the School, or the first day of the month following the date the School receives your completed enrollment form (if you enroll during the 30-day window described in Q.5), whichever is later.

Q.5 When can I enroll in the Plan?

You may enroll within thirty (30) days after the date you first become eligible. Each year thereafter, you will be given an opportunity to enroll for the 12-month period of the Plan Year (September 1 through August 31). You will receive enrollment information prior to the enrollment period each year.

Q.6 How do I enroll?

To enroll, you must select in advance the benefits to be elected under the Plan during the 12-month period of the Plan Year, or the remaining months in the Plan Year if you are hired during the Plan Year. A Flexible Benefits Plan brochure (including a Worksheet) is provided to help you itemize and project your expenses for that Plan Year. This information is used to make your benefit elections on the enrollment form. An enrollment form must be completed each year prior to the beginning of the Plan Year. After you make your annual election, you may change your election only during an Open Enrollment Period or if you have one of the events that permits change during a Plan Year (see Q.8).

If you enroll in the Dependent Care FSA, you must complete a Dependent Care Certification Statement at the beginning of each Plan Year. This statement allows us to verify information regarding your dependent care provider, the ages of the qualifying Dependents, and that if you are married, your Spouse's income exceeds the amount of Dependent care expenses claimed.

If you do not deliver an enrollment form to the School office before the date that you become a Participant in the Plan, you may not pay your required cost for any coverage under the School-sponsored Benefit Plan(s) on a pre-tax basis. Further, your right to reimbursement from the FSAs will also be waived for the remainder of the Plan Year. Instead, you will receive your full pay for the remainder of the Plan Year through the School's regular payroll system.

Q.7 What if I fail to return a completed enrollment form to the School? Can I enroll later?

If you fail to submit a completed enrollment form during the Open Enrollment Period to elect to participate in the Plan, you will not be able to participate in the Plan for that Plan Year. You will be treated as if you had elected to receive all your Compensation in cash, and you will not be allowed to enroll again until the enrollment process begins for the next Plan Year (unless you experience a change in status (see Q.8 below) that would be consistent with allowing you to enroll). If you enroll because of a change in status, you must do so within 30 days of the change in status event.

Q.8 Can I make changes to my election during the Plan Year?

As a general rule, you may only change your benefit election 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. The next sections describe these situations.

IRS "Change In Status"

A change in status is an exception to the rule prohibiting any change during a Plan Year in your benefit election. 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 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;
- An event that causes your Dependent to satisfy or cease to satisfy the requirements of coverage due to the attainment of a specified age, student status, or any similar circumstances; or
- A change in the place of residence of you or your Spouse or Dependent (as long as the move triggers eligibility or causes loss of eligibility under the group health plan, e.g., Eligible Employee or Dependent moves outside HMO service area).

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, if your Spouse or Dependent loses eligibility for our School-provided health coverage and becomes eligible for COBRA, you may increase your Compensation reductions under the Plan in order to pay for the COBRA. (This rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce). Further, with respect to any group term life insurance, disability or dismemberment coverage benefit election, if the change in status is a change in your legal marital status or a change in the employment status of your Spouse or Dependent, an election to increase or decrease coverage will be permitted. Finally, with respect to your Dependent Care FSA, an election change may be made if your Dependent attains age 13 or ceases to be either physically or mentally incapable of self-care.

If you have a change in status during a Plan Year, you may submit a Change in Benefit Election form to the School Office within thirty (30) days after the change in status occurs. The election change will be effective as of the first of the month following the date you submit your completed form. If you do not submit a Change in Benefit Election form within 30 days after the change in status, you must wait until the next Open Enrollment Period to change your election.

FMLA Leave (Applies to Pre-tax Premium Contributions and Health Care FSA Benefits)

You may change an election under the Plan upon FMLA leave, as described in Q.9.

Special Enrollment Rights Under the Health Insurance Portability and Accountability Act - HIPAA (Applies to Pre-tax Premium Contributions, but not to Health Care FSA or Dependent Care FSA Benefits)

You may have special rights under HIPAA to enroll in School-provided health coverage plan in two situations:

- You have lost other group health coverage. This 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 acquire a new Dependent by marriage, birth or adoption.

You must make your new election within 30 days after the event occurs. However, any retroactive enrollment is limited to birth, adoption, and placement for adoption.

Certain Judgments, Decrees and Orders (Applies to Pre-tax Premium Contributions and Health Care FSA Benefits, but not to Dependent Care FSA Benefits)

You may change your election 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:

- Elect coverage for the child if the court order requires you to add the child to the School-provided health coverage in which you are enrolled; or
- Cancel coverage for the child if the court order requires the Spouse, former Spouse or other person to provide coverage. However, coverage can only be cancelled if the child actually becomes covered under the plan of the Spouse, former Spouse or other person to provide coverage.

Medicare or Medicaid Coverage (Applies to Pre-tax Premium Contributions, to Health Care FSA Benefits as Limited Below, but not to Dependent Care FSA Benefits)

If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage and/or the Participant's Health Care FSA coverage may be cancelled, but not reduced. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or

Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage, and/or begin or increase Health Care FSA coverage.

Cost and Coverage Changes (Applies to Pre-tax Premium Contributions and Dependent Care FSA Benefits, but not to Health Care FSA Benefits)

If the cost of coverage under the School's group health plan or one of the School's other insurance plans in which you participate changes during the Plan Year, your Compensation reductions will automatically be increased or decreased to reflect the adjustment in cost. However, if the cost increase is significant, you may either agree to the increase or change your election to another comparable benefit option.

With respect to your Dependent Care FSA, 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. Also, you may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider, or when the Dependent enters or leaves school. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, you may change coverage to reflect the cost of the new service provider; (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage; and (c) if enrollment in school decreases the necessary hours of dependent care, you may reduce your election.

If coverage under the School's group health plan or one of the School's other insurance plans in which you participate is significantly curtailed or ceases during the Plan Year, you may elect to receive coverage under another comparable benefit option. Further, if the School offers a new benefit or coverage option, you may prospectively elect the new option. Conversely, if the School eliminates an option, you may prospectively elect another option which provides similar coverage. However, if you make a change to cease or decrease coverage, we may require certification from you that you are covered, or proof of coverage from the other employer's plan.

If you or your Spouse or Dependent loses coverage under any other insurance plan sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs), you may add coverage for you, your Spouse or Dependent.

Finally, if you or your Spouse or Dependent have a change in coverage under the plan of the employer of your Spouse or Dependent 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 employer's plan, you may make a corresponding election change under this Plan.

Non-Discrimination Rules (Applies to Pre-tax Premium Contributions, Health Care FSA and Dependent Care FSA Benefits)

The School may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q.9 How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If the School is subject to FMLA (Family and Medical Leave Act of 1993; generally, employers with at least 50 employees are subject to the FMLA) and you go on a qualifying leave under the FMLA, to the extent required by the FMLA, your School will continue to maintain your health coverage (including Health Care FSA coverage) on the same terms and conditions as though you

were still active (i.e., the School will continue to pay its share of the premium to the extent you opt to continue coverage). Your School may elect to continue all health coverage (including Health Care FSA coverage) for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and you opt to continue your health coverage (including Health Care FSA coverage), then you may pay your share of the premium in one of three ways:

- (1) with pre-tax dollars to the extent you receive Compensation during the leave, or by pre-paying all or a portion of your share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave Compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such Compensation would normally be available to you, but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year;
- (2) with after-tax dollars while on leave; or
- (3) by other arrangements agreed upon between you and your School (for example, your School may pay for coverage during the leave and withhold “catch up” amounts from your Compensation upon your return from leave).

If your School requires all Participants to continue health coverage and Health Care FSA coverage during the unpaid leave, you may discontinue paying your share of the required premium until you return from leave. Upon returning from leave, you must pay your share of any required premiums that you did not pay during the leave. Payment for your share will be withheld from your Compensation either on a pre-tax or after-tax basis, as you and the School may agree.

If your health coverage or Health Care FSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such benefits, as applicable, upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by the FMLA. You are entitled to have coverage for such benefits automatically reinstated so long as coverage for Eligible Employees on non-FMLA leave is automatically reinstated upon return from leave. But despite the preceding sentence, with regard to Health Care FSA benefits, if your coverage ceased you will be entitled to elect whether to be reinstated in the Health Care 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 FMLA leave during which you did not pay premiums. If you elect the pro-rata coverage, the amount withheld from your Compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health Care FSA coverage will equal the amount withheld before the FMLA leave..

If you terminate coverage in your Health Care FSA during the FMLA leave, your account cannot be used to reimburse expenses incurred during the FMLA leave. If you elect to reinstate your Health Care FSA coverage upon your return, you may not retroactively elect Health Care FSA coverage for claims incurred during the leave period.

Upon your return, you have the choice between:

- resuming coverage at a reduced coverage level (e.g., assume that you elected \$1,200 annual Health Care FSA coverage with \$100 monthly premiums; at the end of month 3 in the 12-month coverage period, you go on a 3-month unpaid FMLA leave and revoke coverage; upon return,

you resume the \$100/month premium, so you have \$900 annual Health Care FSA coverage for the remainder of the coverage period reduced by prior reimbursements (claims incurred during the leave period when coverage was terminated cannot be reimbursed) or,

- resuming coverage at the level in effect before the FMLA leave with make-up contributions (e.g., assume that you elected \$1,200 annual Health Care FSA coverage with \$100 monthly premiums; at the end of month 3 in the 12-month coverage period, you go on a three-month unpaid FMLA leave and revoke coverage; upon return, you elect to resume coverage at the preexisting \$1,200 level, so make-up contributions of \$300 are required; therefore, upon return, the premium is \$150/month, and you have \$1,200 annual coverage for the remainder of the coverage period reduced by prior reimbursements (claims incurred during the leave period when coverage was terminated cannot be reimbursed).

For purposes of the Dependent Care FSA, expenses you incur while on a leave of absence are not eligible for reimbursement since they are not expenses you pay so that you can work. When you return from your leave of absence, the School will continue your previous payroll deduction amounts unless you instruct the School to accelerate your deductions so that your original annual election will be met (to obtain reimbursement for your Dependent care expenses incurred prior to and after your leave of absence).

Non-FMLA Leaves of Absence. If you go on an unpaid Non-FMLA leave of absence that does not affect eligibility, then you will continue to participate and the premium due for you will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by your School. If you go on an unpaid leave of that affects eligibility, you may continue your health coverage (including Health Care FSA coverage) under COBRA (see Q.23).

Q.10 Can you tell me more about the Flexible Spending Accounts?

There are certain health care expenses that you or your family may incur that are not covered under the School-sponsored Benefit Plan(s) or your Spouse's employer's group health plan if you have coverage under your Spouse's plan. Also, if you have children or other Dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these health care and Dependent care expenses under your FSAs. Your FSAs allow you to pay certain qualifying expenses using "pre-tax" income rather than "after-tax" income. Your pay reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The FSAs operate as follows. The School will establish a separate bookkeeping account in your name for each tax-free reimbursement benefit you choose for a Plan Year. For example, if you choose both of the tax-free reimbursement benefits available under the Plan, the School will establish the following accounts in your name:

- Health Care FSA and
- Dependent Care FSA.

The School will allocate your pay reductions to each account in the amount indicated in your enrollment form. When a claim for reimbursement is paid, the amount paid will be subtracted from the applicable FSA. You may not use amounts allocated to one account to receive reimbursement for another type of account.

Q.11 How do I decide how much to set aside for the Health Care FSA?

It is entirely up to you to determine whether to allocate any pay reductions to a Health Care FSA and, if

so, how much to reduce your pay. However, the maximum amount you may have credited to your Health Care FSA for a Plan Year is \$2,500.

If you know you will have qualifying health care expenses during the Plan Year that will not be covered by your health insurance plan or by any other source, you should consider putting enough in your Health Care FSA to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying health care expenses for which you are responsible. However, you will still be required to pay for any expenses that exceed the amount in your account.

In deciding on the amount to put in your account, it's wise to be conservative and use the account for *predictable* expenses. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next Plan Year. At the end of the Plan Year, all unused amounts must be forfeited. Therefore, careful planning is required.

Q.12 What types of expenses are eligible for reimbursement from the Health Care FSA?

Your qualifying health care expenses may be reimbursed under the Plan. Qualifying health care expenses may be incurred for:

- You;
- Your spouse;
- A dependent you list on your federal tax return; or
- A person you could have listed as a dependent on your federal tax return if that person had not received \$1,000 or more of gross income or had not filed a separate return.

Qualifying health care expenses are only those medical care expenses that are eligible for reimbursement on a tax-free basis under Section 105(h) of the Internal Revenue Code. They include, for example, expenses you have incurred for:

- Co-pays and deductibles you must pay before your medical or dental plan begins to pay benefits
- Medicine, drugs, birth control pills, vaccines and vitamins, any of which require a prescription
- Over-the-counter (OTC) drugs incurred for medical care
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts
- Medical examinations, x-rays and laboratory services, insulin treatments and whirlpool baths the doctor ordered for a specific medical condition
- Nursing help. If you pay someone to do both nursing and housework, only the nursing help may be reimbursed as a qualifying health care expense. However, housework may qualify for reimbursement under your Dependent Care FSA
- Hospital care, clinic costs and lab fees
- Medical treatment at a center for the treatment of alcohol or other substance abuse
- Medical aids such as hearing aids (and batteries), dentures, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining these aids

- Vision expenses such as vision examinations, prescription eyeglasses, contact lenses and solutions, and laser eye surgery (e.g., lasik or radial keratotomy)
- Ambulance service and other travel costs to get health care, including airfare. If you used your own car, you may be reimbursed at the IRS approved rate per mile for transportation expenses (12 cents for 2003). You must submit a copy of your insurance Explanation of Benefits or an itemized receipt or statement from your provider along with the mileage log in order to be reimbursed for mileage. You may also add parking and tolls that you pay for medically related visits
- Smoking cessation programs (including prescription and OTC drugs for smoking cessation)
- Lodging while away from home as long as the lodging is primarily for and essential to the medical care being provided, not to exceed \$50 for each night for each person. For example, if a parent is traveling with a sick child, up to \$100 per night may be reimbursed
- Personal use items (such as special pillows or mattress covers due to an allergy condition); however, only the excess of the cost of the special form over the cost of a normal form may be reimbursed. A physician's letter of medical necessity may also be required
- Expenses for weight-loss programs and drugs as treatment for obesity or another specific medical condition (e.g., high blood pressure). This includes the fees to join the program, but not the cost of the 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 check items like blood pressure and cholesterol
- Cord blood storage if a child is born with a medical condition where cord blood may be needed in the future (but not if storing it just in case of a future need).

Many of the expenses listed above may be covered by other Employer-sponsored Benefit Plan(s). Any expenses covered by any other plan or source will not be treated as a qualifying health care expense under the Health Care FSA.

You cannot obtain reimbursement for expenses that are not medical care expenses eligible for reimbursement on a tax-free basis under Section 105(h) of the Internal Revenue Code. For example, you cannot obtain reimbursement for the following expenses:

- The cost of health coverage. For example, you cannot obtain reimbursement for health insurance premiums you pay to obtain coverage under our Employer-sponsored Benefit Plan(s) or for the premium your spouse pays to obtain health coverage under his or her employer's group insurance plan. You also cannot obtain reimbursement for the premium for an individual health policy or for coverage under your spouse's employer's plan. (However, you can pay your portion of the required cost of coverage for our Employer-sponsored Benefit Plan(s) on a pre-tax basis outside of the Health Care FSA. See Q.3.)
- Life insurance or income protection policies
- The hospital insurance benefits tax withheld from your pay as part of the Social Security tax
- Nursing care for a healthy baby. However, this expense may qualify for reimbursement under your Dependent Care FSA.

- Illegal operations or drugs
- Expenditures for general good health, including OTC drugs, dietary supplements, drugs taken for weight loss (not related to a specific medical condition) and vitamins
- Programs on health-related topics if they are merely beneficial to the general health of the individual (and not related to a specific medical condition), and travel your doctor told you to take for rest or change
- Cosmetic procedures (including teeth bleaching, electrolysis, hair transplants and Rx or OTC drugs taken for cosmetic reasons), unless necessary because of injuries you receive, congenital disfigurement, or a disfiguring disease
- Long-term care expenses
- Health club dues
- Meals that are not part of inpatient care
- Vision warranties or services agreements
- Non-prescription eyeglasses or sunglasses, including sun clips
- Expenses paid or payable by insurance, or reimbursed by any other source
- Programs or prescriptions to control weight, unless a medical necessity exists
- PPO network discounts

Q.13 How do I make a claim for reimbursement for health care expenses?

You should send your claims for reimbursement of qualifying health care expenses to the Benefit Administrator (see the last section of this Summary Plan Description). You will need to provide the information required on the claim reimbursement form furnished by the School or the Benefit Administrator and proper documentation of your expense. Proper documentation includes legible itemized receipts or statements which include the date of service for the charge, the description and amount of the charge, the patient name of the person for whom the expense was incurred and the name and address of the person or entity to which the expense was paid. Credit card slips, check copies, cash register receipts or “balance due” statements cannot be accepted as the itemization required to process the claim.

The Benefit Administrator may request a letter of medical necessity from your physician for certain charges (e.g., massage therapy, exercise equipment, etc.). The letter must reference the specific medical condition, the specific treatment recommended and the length of time that treatment is recommended.

For orthodontia expense reimbursement, the Benefit Administrator may require that you submit a copy of your Truth in Lending Statement (contract/treatment plan) with your initial claim submission, itemizing the estimated treatment period, initial down payment and amount of monthly payments, and amount reimbursable by insurance, if any. You may submit a copy of your monthly payment coupon and/or itemized receipts each time you request reimbursement for ongoing treatment. The Plan cannot reimburse for future service or for the portion of treatment occurring in a subsequent Plan Year. If you choose to prepay orthodontia expenses in a lump sum at the beginning of treatment, only those services actually rendered during the Plan Year may be considered for reimbursement (i.e., your reimbursement will be prorated based on the months of treatment occurring in the Plan Year).

Your Health Care FSA resembles an insurance policy. You are entitled to uniform coverage throughout the Plan Year. For example, if you incur \$100 of qualifying health care expenses during the first month of the Plan Year, you may be reimbursed for those expenses immediately, even if you only have \$50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your Health Care FSA for the Plan Year. Also, only claims for qualifying expenses will be reimbursed.

Your Dependent Care FSA reimbursement will be limited to the amount that you have had deducted from your paycheck as of the date your claim is submitted. (The annual level of coverage is not available to you from the beginning of the Plan Year as it is for the Health Care FSA.)

You are responsible for making sure that duplicate claims are not submitted for reimbursement. Duplicate claims will be flagged based on the date of service, patient name and amount, and such duplicate claims will be denied as previously considered.

Claims are processed within two business days of receipt by the Benefit Administrator. Reimbursement checks are issued daily.

Q.14 How do I decide how much to set aside for the Dependent Care FSA?

It is entirely up to you to determine whether to allocate any pay reductions to your Dependent Care FSA and, if so, how much to reduce your pay. If you know you will have Dependent care expenses during the Plan Year, you should consider setting aside enough in your Dependent Care FSA to cover these planned-for expenses. The amount in your account will be used to pay all the Dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses that exceed the amount in your account.

In deciding on the proper amount to put in your account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation or if your child is ill, you should take this into consideration when you determine the amount you wish to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next Plan Year. At the end of the Plan Year, all unused amounts must be forfeited. Therefore, careful planning is required.

Q.15 What is the difference between the Dependent Care FSA and the Dependent Care Credit?

The Internal Revenue Code gives you two choices in the treatment of Dependent care expenses for income tax purposes. First, you may pay for Dependent care expenses with "pre-tax" income through the Plan. Second, you may claim a tax credit for Dependent care expenses (a percentage based on your combined adjusted gross income). However, any amount you claim under the dependent care credit will be reduced dollar-for-dollar by the amount you are reimbursed under the Plan. If your family income is greater than \$25,000, it is generally more advantageous to participate in the Dependent Care FSA under the Flexible Benefits Plan than to claim the dependent care tax credit. Ask the School office for a worksheet to help you compare the tax savings.

Regardless of which method you choose, please be aware that you must state on your Federal income tax return the name, address and social security number of the person (or Tax I.D. number if a corporation) who is providing the dependent care to your Dependents by completing Form 2441.

Q.16 What is the Dependent Care Credit?

The dependent care credit is an allowance for a percentage of your annual Dependent care expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax

credit would be prior to 2003, you may take into account only \$2,400 of such expenses for one Dependent, or \$4,800 for two or more Dependents. Depending on your combined adjusted gross income (income of you and your Spouse, if married), the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of \$720 for one Dependent or \$1,440 for two or more Dependents) to a minimum of 20% of such expenses (producing a maximum credit of \$480 for one Dependent or \$960 for two or more Dependents). The maximum 30% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross incomes over \$10,000.

Illustration: Assume that in 2002, you have one Dependent for whom you have incurred Dependent care expenses of \$3,600, and that your adjusted gross income is \$20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first \$2,400 of expenses. The percentage is 25% (it comes from a table on IRS Form 2441). Thus, your tax credit would $\$2,400 \times 25\% = \600 . If you had incurred the same expenses for two or more Dependents, your credit would have been $\$3,600 \times 25\% = \900 , because the entire expense would have been taken into account, not just the first \$2,400.

Please note: Under the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), effective for tax years beginning after December 31, 2002, a taxpayer may take into account \$3,000 (increased from \$2,400) of employment-related expenses for one qualifying individual, and \$6,000 (increased from \$4,800) for two qualifying individuals. EGTRRA also increases the percentage for determining the dependent care credit to 35%. The dependent care credit will start to phase out at an adjusted gross income of \$15,000.)

For more information about how the dependent care credit works, see IRS Publication 503 (“Child and Dependent care expenses”). You may also wish to consult a tax advisor.

Q.17 If I participate in the Dependent Care FSA, will I still be able to claim the Dependent Care Credit on my Federal Income Tax Return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified Dependent care expenses may be eligible for the dependent care credit. The \$2,400 and \$4,800 limits are reduced dollar-for-dollar by the amounts contributed to the Dependent Care FSA.

For example, Employee A has one child in day care and has \$2,000 in expenses. This Employee contributes \$1,500 to the Dependent Care FSA. Therefore, Employee A can take a tax credit on the remaining \$500 of expenses.

Employee B has two children in day care and is participating at the maximum level allowed under the Plan, or \$5,000 per calendar year. Therefore, since Employee B has exceeded the \$4,800 of expenses allowed for the tax credit, no further credit is allowed.

Q.18 What types of expenses are eligible for reimbursement from the Dependent Care FSA?

Your Dependent care expenses may be reimbursed under the Plan. Dependent care expenses are your expenses for certain services that your Dependents need in order for you to be employed by the School. If you are married, your Spouse must also be working, or be a full-time Student. For purposes of the Plan, a child of divorced parents who is under age 13 or is either physically or mentally incapable of self-care 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.

The types of services covered are:

- Care for your Dependent in your home (such as babysitting) or outside of your home (such as in a day care center or preschool), if the Dependent is either:
 - Under age 13; or
 - Physically or mentally incapable of self-care.
- Household Services for the maintenance of your home (such as for a domestic maid or cook), as long as the services are performed in part for the benefit of your Dependent.

You cannot obtain reimbursement for the following expenses:

- Amounts paid for food, clothing, education and entertainment. However, you can include small amounts paid for these items if they are incident to (and cannot be separated from) the cost of caring for the qualifying Dependent.
- Educational expenses for grades kindergarten and beyond. However, if a portion of private kindergarten tuition is for child care, that portion may be reimbursed. (The school must provide a statement showing a break down of educational vs. child care expenses.)
- Overnight camp expenses (however, day camp expenses are eligible for reimbursement as long as they are employment related).
- Transportation expenses including the cost of bus, subway, taxi or private car. Also, if you pay the transportation cost for the care provider to come to your home, you cannot submit this expense as a work-related expense.

Q.19 May amounts paid to my relatives be reimbursed?

You may hire whomever you wish to provide services to your Dependents. However, federal law provides that Dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your Dependents;
- Your Spouse; or
- Your child (even if not your Dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Q.20 Are there limits on how much may be reimbursed?

Federal law limits the amount of Dependent care expenses that may be reimbursed under the Plan. Generally, the limit is \$5,000 per calendar year (or \$2,500 if you are married and file a separate tax return).

The amount of Dependent care expenses claimed cannot exceed the lower of your Earned Income, or your Spouse's Earned Income. Further, if your Spouse is a full-time Student or is either physically or mentally incapable of self-care for any month in which you have Dependent care expenses, your Spouse will be considered to have the following pay for that month:

- \$200, if you have Dependent care expenses for one Dependent; or

- \$400, if you have Dependent care expenses for more than one Dependent.

These limits will increase effective January 1, 2003 to \$250 and \$500 respectively.

Q.21 How do I submit a claim for reimbursement for Dependent care expenses?

You should submit your claims for reimbursement of Dependent care expenses to the Benefit Administrator (see the last section of this Summary Plan Description). You will need to provide the information required on a claim reimbursement form furnished by the School or the Benefit Administrator, and include proper documentation of your expense. This documentation includes the "from/through" date of service, a description of the charge (i.e., child care or pre-school), the amount of the charge, the Dependent's name and the name of your dependent care provider. Sample receipts can be obtained from the Benefit Administrator. As an alternative to submitting a separate receipt, you may have your dependent care provider complete the receipt on the reverse side of the claim form.

Your claim cannot be submitted until after the services have actually been rendered. For example, if you pay your child care expenses weekly on Monday for that week, you should submit your claim on Friday after the services have been rendered. If you pay your child care expenses on a monthly basis, you will need to wait until the last day of the month to submit for reimbursement.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the Plan Year. Also, only claims for qualifying expenses will be reimbursed.

Q.22 When are expenses for health care and dependent care incurred?

To be reimbursed, health care or Dependent care expenses must have been incurred during the Plan Year. An expense is *incurred* when the service that gives rise to the expense is provided; when the expense is billed or paid is irrelevant.

Q.23 What happens if I terminate employment during the Plan Year?

If you terminate employment you will be ineligible to have any additional pay reductions under the Plan credited to your Health Care FSA or Dependent Care FSA. If you have amounts remaining in your accounts, you may continue to turn in claims for reimbursement of health care expenses incurred before you terminated employment. With respect to your Health Care FSA, you will not be eligible to be reimbursed for claims for reimbursement of expenses incurred after you terminated employment, except as explained in the next paragraph. Dependent care expenses incurred after your date of termination, but before the end of the Plan Year may be submitted within 90 days following the end of the Plan Year, as long as the expenses are employment related (in other words, an expense you pay so you can work or look for work).

If you are rehired after 30 days during the same Plan Year of your termination of employment, there are special rules which may restrict your participation in the Plan until the following Plan Year. If you terminate and are rehired, you should contact the School office for further details regarding these special eligibility requirements.

You have the option of continuing to participate in your Health Care FSA after you terminate participation to the extent required by the federal law known as "COBRA." Where the School is subject to COBRA, if the amount of benefits remaining is more than the cost of COBRA coverage, 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 (e.g., your Health Care FSA is not considered an excepted benefit under HIPAA).

If you are eligible to elect COBRA with respect to your Health Care FSA, you may continue participation by making after-tax contributions to the Plan on a monthly basis in an amount equal to 102% of the pay reductions and any employer contribution or credit, if applicable, that were allocated to your Health Care FSA each month before you terminated participation. After-tax contributions for a month are due on 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.

Q.24 When would I risk forfeiting my spending account benefits?

Your pay reductions for each Plan Year may only be used to reimburse qualifying expenses incurred during that Plan Year. You are not allowed to carry over any unused amounts to the next Plan Year. You are also not allowed to transfer unused amounts from one FSA to another FSA. Federal law requires that amounts left after reimbursing expenses incurred during the Plan Year must be forfeited. Remember, for purposes of the Plan, an expense is "incurred" when the service is rendered or the supply is provided, not when you pay for the expense or are billed for the expense.

A forfeiture will occur if you fail to use the entire amount in your FSAs. You should be careful not to overestimate your expected expenses when you turn in your enrollment form for the Plan Year. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have a forfeiture.

Claims for expenses incurred during a Plan Year may only be reimbursed out of your account for that Plan Year. All claims incurred during a Plan Year must be turned in no later than 90 days after the end of the Plan Year. If you do not turn in a claim by the required date, the claim will be denied. Any amount then remaining in your account will be forfeited.

Q.25 What happens if my claim for benefits is denied?

Underlying Health Insurance Plan Coverage Claims. If your claim is for a benefit under the health insurance plan, you will generally proceed under the claims procedure applicable under that plan or policy, as described in the Plan Document or Summary Plan Description for the health insurance plans.

Claims Under the Plan. However, if (a) a claim for reimbursement under the Health Care FSA or Dependent Care FSA components of the Plan is wholly or partially denied, or (b) you are denied a benefit under the Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Plan), then the claims procedure described below in this Q.25 will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator or Benefit Administrator within 30 days of the date the Plan Administrator or Benefit Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals by Participant. If your claim is denied in whole or in part, you (or your authorized representative) may request review upon written application to the Plan Administrator or a committee appointed by the Plan Administrator that acts on behalf of the Plan Administrator with respect to appeals. Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Your appeal will be reviewed and decided by the Plan Administrator or the committee appointed by the Plan Administrator in a reasonable time not later than 60 days after the Plan Administrator or the committee appointed by Plan Administrator receives your request for review. The Plan Administrator or the committee appointed by the Plan Administrator may, in their discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- A. The specific reason(s) for the decision on review;
- B. The specific Plan provision(s) on which the decision is based;
- C. A statement of your right to review (upon request and at no charge) relevant documents and other information;
- D. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- E. A statement of your right to bring suit under ERISA § 502(a) (where applicable).

General Information About the Plan

Plan Name: CSI Flexible Benefits Plan

Type of Plan: Flexible Benefit Plan under Internal Revenue Code Section 125

Plan Year: September 1 through August 31

Plan Number: 511

Type of Plan Administration and Funding Medium: This Plan is administered by the Trustees of Christian Schools International and through an administrative agreement with the Benefit Administrator. Claims for benefits are sent to the Benefits Administrator at:

Employee Benefit Strategies, L.L.C.
229 E. Michigan Avenue, Suite 235
Kalamazoo, MI 49007
(616) 344-2500 or (800) 325-7477

The Plan is currently funded by way of employee contributions.

Participating Member School: Your School Name

Participating Member School's Employer Identification Number: Your School's EIN

Benefit Administrator: Employee Benefit Strategies, L.L.C.

Plan Administrator and Named Fiduciary: Trustees of Christian Schools International
3350 East Paris Avenue, SE
P.O. Box 8709
Grand Rapids, MI 49512
(616) 957-1070

Agent for Service of Legal Process: Trustees of Christian Schools International
3350 East Paris Avenue, SE
P.O. Box 8709
Grand Rapids, MI 49512

Service of legal process may also be made on the Benefit Administrator.

How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator, the Trustees of Christian Schools International. Christian Schools International is the Named Fiduciary for the Plan. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

Christian Schools International will indemnify each Participating Member School's Eligible Employee to whom it or the Plan Administrator has delegated responsibilities for the operation and administration of

the Plan against any and all claims, loss, damages, expense and liability arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the Eligible Employee.

The benefits provided under the Plan will be paid, to the extent permitted by ERISA and the Internal Revenue Code, from the general assets of the Participating Member School, employee contributions, and insurance contracts. Nothing in this Plan will be construed to require the Participating Member School to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund account or asset of the Participating Member School from which any payment under the Plan may be made.

The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of Participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the authority contemplated by ERISA and the Code with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the Plan. The Plan Administrator has the requisite discretionary authority and control over the Plan to require deferential judicial review of its decisions.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan. The Plan Administrator is only delegating its discretionary authority to determine eligibility, rights to benefits and to construe the Plan with respect to the specific benefit the insurer is providing; it retains full discretionary authority with respect to the rest of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary to the extent provided in ERISA §405(a).

If you have any general questions (including questions concerning eligibility for benefits) regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning the amount of any benefits payable under the Plan, please contact the Benefits Administrator.

Amendment or Termination of the Plan

The Plan Administrator has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by an authorized representative of the Plan Administrator, who is authorized to amend or terminate the Plan and to sign contracts with the Benefits Administrator or other carriers, including amendments to those contracts.

Upon termination of the Plan, only benefits to which you became entitled, or expenses which were incurred prior to termination will be covered under the Plan.

Limitation on Rights

The Plan does not constitute a contract between you and the Participating Member School or Christian Schools International, nor is it to be consideration or inducement for your employment. Nothing contained in the Plan gives you the right to be retained in the service of the Participating Member School or to interfere with the right of the Participating Member School to discharge you at any time, with or without cause (subject only to the provisions of any relevant collective bargaining agreement), regardless of

the effect which that discharge will have upon you as a Participant in the Plan.

Claims Procedures

The Benefit Administrator is responsible for evaluating all initial benefit claims under the Plan. The Benefit Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The Benefit Administrator has the right to require such other evidence as it deems necessary in order to decide your claim.

If the Benefit Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial, as outlined in Q.25.

Statement of ERISA Rights

As a Participant in the CSI Flexible Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may be able to continue your participation in the Health Care FSA if there is a loss of coverage under the Plan as a result of a qualifying event. If you are eligible to elect COBRA, you are required to pay for such coverage on a post-tax basis. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If you request a copy of Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Ad-

administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Waiver

Failure by the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether or not the circumstances are the same.

Errors

An error cannot give a benefit to you if you are not actually entitled to the benefit.

Discretion / Nondiscrimination

Wherever it is provided in the Plan that the Plan Sponsor may perform or not perform any act, or permit or consent to any action, non-action or procedure, or wherever it shall be given discretionary power or authority, it shall have exclusive discretion in the premises; provided, however, that it shall not exercise its discretion in such a manner as to violate the Internal Revenue Code or ERISA or knowingly to discriminate either for or against any Eligible Employee, retiree, Participant or Covered Person or any group of such persons.

Entire Representation

This document, along with any summary, schedule of benefits, separate insurance contract or certificate, or booklet describing any health benefits, together are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral). This document may be amended or supplemented only in a writing signed by the Plan Sponsor or its designee.

Acceptance; Cooperation

If you accept benefits under this Plan, you are considered to have accepted its terms, and agree to perform any act and to execute any documents which may be necessary or desirable to carry out this Plan or any of its provisions.

Governing Law

The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

Construction

Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural should be read as the singular, and the singular as the plural.

Non-Assignability of Rights

No interest under the Plan is subject to assignment or alienation, wherever voluntary or involuntary. Any attempt to assign or alienate any interest will be void.

Severability

The enforceability of any provision of the Plan shall not affect the enforceability of the remaining provisions of the Plan.

Compliance with Tax Law

This Plan is intended to comply with all applicable law, including §125 of the Code. It shall be considered amended to the extent necessary to comply with §125. However, neither the Plan, Plan Sponsor, the Plan Administrator, the Participating Member School nor any Plan fiduciary represents or guarantees that this Plan in fact meets requirements of any provision of the Code. Any other provision of this Plan notwithstanding, individuals who are not treated as Eligible Employees for purposes of the tax treatment of any contribution to any Benefit Program are not eligible to participate in the Plan. The Plan cannot be operated so as to defer the receipt of Compensation in a manner that violates §125. Plan benefits under any of the Flexible Benefits Programs not used during a Plan Year will be considered to be forfeited at the end of that Plan Year.