ADRIAN PUBLIC SCHOOLS CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

Amended as of January 1, 2019

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ADRIAN PUBLIC SCHOOLS CAFETERIA PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in

Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Premium Expense Account and Health Savings Account once you have satisfied the conditions for coverage under our group medical plan. You will be eligible to join the Health Flexible Spending Account and Dependent Care Flexible Spending Account even if you are not eligible under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

If your employment is subject to an individual agreement or a collective bargaining agreement between the Employer and any collective bargaining group/unit (a union), you will be eligible to participate in the Plan when and to the extent so provided and acknowledged through individual agreement or the collective bargaining process.

3. When is my entry date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. Are there any employees who are not eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

- Employees who are leased employees.
- Independent contractors.

5. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. If you receive a reimbursement for an expense under the Plan, you cannot claim a Federal

income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan after application of the Employer Contribution. These amounts will be deducted from your pay over the course of the year.

2. How much will the Employer contribute each year?

If you have other medical coverage and opt out of our group medical coverage, we will contribute a discretionary amount which we will determine prior to the beginning of each Plan Year. This contribution shall be in the form of taxable cash and will be made on a pro rata basis during the year.

3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

4. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

5. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change

that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do apply to the Health Flexible Spending Account, and you may change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

7. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV
BENEFITS

1. What benefits are available?

Under our Plan, you can choose to receive your entire compensation and your Employer's contribution or use a portion to pay for the following benefits or expenses during the year:

Health Flexible Spending Account:

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan or privately held insurance policies and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you, your spouse and your dependents. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. You are not eligible for the Health Flexible Spending Account if you contribute to the Health Savings Account.

Beginning January 1, 2011, you may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is $2,700. This amount may be adjusted in future years for cost of living increases. If you join the Health Flexible Spending Account on any day other than the first day of the Plan Year, your maximum contribution will be pro-rated. For example, if you join the Health Flexible Spending Account on July 1, your maximum contribution is $1,350.

In order to be reimbursed for a health care expense, you must submit to the itemized bill from the service provider or an explanation of benefits from the insurance carrier. Reimbursement from the account shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

Dependent Care Flexible Spending Account:

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent for purposes of the Dependent Care Flexible Spending Account is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves and have the same residence as you for more than one-half of the taxable year. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws:

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An individual who provides care inside or outside your home: The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly deemed earned income of $250 for one dependent or $500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

Health Savings Account:

If you participate in a high deductible health plan, you may make contributions to your Health Savings Account, which enables you to pay for expenses which are not covered by our medical plan and save taxes at the same time. Please see your Administrator for further details.

Premium Expense Account:

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses for you, your spouse and your eligible children up to age 26 under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Dental insurance premiums.
- Vision insurance premiums.
- Prescription drug coverage.
- Long Term Disability
- Other insurance coverage that we may provide, including group-term life insurance.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

Cash-in-Lieu of Medical Coverage:

If you provide adequate proof of other medical coverage, and opt out of the Employer's group medical plan, you may receive a cash contribution in an amount determined each year by the Employer prior to the beginning of the Plan Year. The amount of such cash contribution shall be communicated to you on the applicable election form, unless otherwise specifically provided for in a collective-bargaining agreement. This cash contribution shall be made on a pro rata basis for each pay period, in accordance with the Employer's normal payroll practice.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable, forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Except for the $500 carryover described in the next paragraph, any monies left at the end of the Plan Year will be forfeited, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. Because it is possible that you might

forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

Effective January 1, 2014, you may carryover up to $500 left in your Health Flexible Spending Account at the end of the Plan Year to the next Plan Year and use it for expenses incurred during the next following Plan Year.

> *Example*: After she has been reimbursed for all eligible health care claims incurred in 2018, Robin has a $500 balance remaining in her Health Flexible Spending Account as of December 31, 2018. The $500 remaining balance can be carried over and used for claims incurred in 2019, in addition to any amounts that Robin elects to contribute to her Health Flexible Spending Account in 2019.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return. Regardless of which option you elect, you must pay for your coverage in full by June 30, which is the end of our fiscal year.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses from the balance remaining in your dependent care account at the time of termination of employment. Such reimbursement requests can be made for qualifying dependent care expenses incurred after you terminate, through the end of the Plan Year. However, no further salary redirection will be made on your behalf after you terminate unless you elect to continue participation in the Dependent Care Flexible Spending Account.

(c) If you elect to continue your participation in the Dependent Care Flexible Spending Account, you may continue to seek reimbursement from the Dependent Care Flexible Spending Account for qualifying dependent care expenses incurred after you terminate, through the end of the Plan Year. To continue participation, the balance of your Dependent Care Flexible Spending Account election for the Plan Year shall be deducted from your final paycheck.

(d) Your Health Savings Account amounts will remain yours even after your termination of employment.

(e) You may elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year by electing COBRA continuation coverage.

(f) If you elect to continue your participation in the Health Flexible Spending Account under COBRA, you may continue to seek reimbursement from the Health Flexible Spending Account for eligible Medical Expenses incurred after you terminate, through the end of the Plan Year. To continue participation, you must make monthly after-tax contributions or you may elect to have the balance of your Health Flexible Spending Account election for the Plan Year deducted from your final paycheck on a pre-tax basis.

(g) If you elect not to continue participation in the Health Flexible Spending Account, participation will terminate and no further salary redirection will be contributed on your behalf. You will be able to submit claims for health care expenses incurred prior to the date you terminate, up to the remaining amount allocated to your account.

6. Can I continue my coverage under COBRA?

Under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), you and your dependents can purchase a temporary extension of Health Flexible Spending Account coverage if you lose coverage due to certain family or employment status changes. If you become eligible for continued coverage, you and your eligible dependents will receive a notice that explains the terms and conditions that apply to continuation coverage.

To elect continuation coverage, you must return your election form to the Administrator within 60 days from the later of the date coverage ends or the date of the notice. If you do not return the election form, you may not continue your coverage. You can continue coverage only if you are covered under the Health Flexible Spending Account at the time you experience one of the status changes outlined below.

The continued coverage requires that you pay the full cost of coverage plus a 2% administration fee. Payments may be made monthly on an after-tax basis or can be withheld in full on a pre-tax basis from your final paycheck. Only those already covered are eligible.

You and Your Dependents

Both you and your covered eligible dependents may continue your Health Flexible Spending Account coverage at the same level you were covered under at the time coverage ends as a result of one of the following events:

- You terminate employment for reasons other than gross misconduct.
- Your hours are reduced.
- You retire.

Coverage may be continued for the remainder of the Plan Year in which coverage ended and only if you and your dependents may be reimbursed for an amount that is greater than the maximum amount of your required payment for continuation coverage. You may not continue coverage after the end of the Plan Year in which the event occurs.

Example: You elect to deposit $1200 in your account. On July 31, you terminate employment. As of that date, you have been reimbursed for $300 of health care expenses and can be reimbursed for an additional $900 in health care expenses in that plan year. The plan can charge you $510 for the remaining five months of coverage during the remainder of the plan year ($100 per month plus a 2% administrative fee). Because the plan's charge ($510) for continuation coverage is less than the amount of health care expenses that you could submit for reimbursement ($900), the plan will offer you the right to continue coverage for the remainder of the plan year, but not for any subsequent plan year.

Continuation coverage will not continue for the remainder of the Plan Year if:

- You and your dependents become covered under another group health plan,
- The Employer's plan ends,
- You or your dependents become entitled to Medicare benefits, or

- A premium is not paid when due.

Dependents

Your covered eligible dependents may continue Health Flexible Spending Account coverage at the same level of coverage you originally chose if their coverage ends as a result of one of the following events:

- Divorce or legal separation,
- Dependent child becomes ineligible,
- You die, or
- You become entitled to Medicare benefits.

You or your dependent must notify the Administrator in writing within 60 days following a divorce, legal separation or a child's loss of dependent status.

Coverage may be continued for the remainder of the Plan Year in which coverage ended and only if your dependents may be reimbursed for an amount that is greater than the maximum amount of the required payment for continuation coverage. Coverage may not be continued after the end of the Plan Year in which the event occurs. Continuation coverage will not continue for the remainder of the Plan Year if:

- Your dependents become covered under another group health plan,
- The Employer's plan ends,
- A dependent becomes entitled to Medicare benefits, or
- A premium is not paid when due.

7. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by

the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Adrian Public Schools Cafeteria Plan is the name of the Plan.

Your Employer has assigned Plan Number 511 to your Plan.

The provisions of your amended Plan become effective on January 1, 2019. Your Plan was originally effective on October 1, 1991.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Adrian Public Schools
785 Riverside Avenue, Suite 1
Adrian, Michigan 49221-1404
38-6002265

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Assistant Superintendent
785 Riverside Avenue, Suite 1
Adrian, Michigan 49221-1404
(517) 264-6647

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Adrian Public Schools
785 Riverside Avenue, Suite 1
Adrian, Michigan 49221-1404

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Adrian Public Schools
785 Riverside Avenue, Suite 1
Adrian, Michigan 49221-1404

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 30 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care or medical expense claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

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SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.