Plan Document and Summary Plan Description for the JCISD Employee Benefit Plans

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EFFECTIVE DATE: 10-1-2016

Introduction

Jackson County Intermediate School District (the “Employer” or “Company”) is pleased to offer benefits through the JCISD Employee Benefit Plan. These benefits are a valuable and important part of your overall compensation package.

This booklet provides important information about the Benefit Program(s) covered under the Plan. It serves as the Plan document and the Summary Plan Description (“SPD”) for the JCISD Employee Benefit Plan (“the Plan”). It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended, and as may be applicable.

The “Benefit Programs” covered by this Plan are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits and other descriptive documents relating to each Benefit Program (collectively, the “insurance certificates”) are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs. This booklet is not intended to give any substantive rights to benefits that are not already provided by the insurance certificate for an insured benefit. If the terms of this booklet conflict with the substantive terms of an insurance certificate for an insured Benefit Program, the terms of the insurance certificate will control, unless otherwise required by law.

This Plan document/SPD replaces all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference. We encourage you to read this booklet and insurance certificates and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

Both unionized and non-unionized employees are eligible for benefit programs described in Appendix A. Your specific benefit eligibility will be dependent upon the terms of your applicable collective bargaining agreement or employee handbook, but employees who are full-time active employees normally scheduled to work 30 or more hours per week are generally eligible to participate in a wider scope of benefits than a part-time employee who is normally scheduled to work 20 or more hours per week. To participate in these employee benefits, employees must be 18 years of age, work at least 20 hours per week and at least 9 months per year. See the applicable union contract or the Administrative, Managerial, Technical and Operations employee handbook for specific eligibility requirements for your group.

Union employees are eligible for coverage if your benefits are covered under the terms of the collective bargaining agreement between the Employer and the JIEA; CCEA; ESPA; Transportation.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the Employer payroll, as determined by the Employer.

The Employer's determination of eligibility is conclusive and binding for Plan purposes. No reclassification of a person's status, for any reason, by a third party (whether by a court, governmental agency or otherwise) will change a person's eligibility for benefits under the Plan.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

When Coverage Begins

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for

that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following your date of hire.

Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements to be covered under the Plan.

Unless stated otherwise in your insurance certificates, coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage. If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 30 days of the date on which they became eligible. If you wait longer than 30 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

Look-back Measurement Method for Determining Full-time Employee Status

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for

coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan's Benefit Programs. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator. [NOTE: if a particular negotiated benefit plan is subject to a mid-year renewal and re-rating, employees who choose that plan during annual open enrollment may have a mid-year adjustment in their required premium contribution.]

For most benefits you may pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars.

You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

Initial Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

The elections you make will remain in effect until the next December 31, unless a permitted election change event occurs (see below). Your insured benefits may have a different coverage period. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. After your initial enrollment, you will enroll during the designated annual open enrollment period.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. In general, the elections you make will take effect on January 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. Also, you should refer to the insurance certificate provided by the Insurer for more information on how your benefits are affected by the policy year, including whether your deductible and out-of-pocket expenses accumulate over the Plan Year, policy year or other 12-month period.

Special Enrollment Rights

You may enroll for coverage outside of the Plan's initial and annual open enrollment periods if you experience a special enrollment event, as described below. Special enrollment rights apply to the Plan's medical benefits. These rights, however, may not apply all Benefit Programs (for example, these rights do not apply to Benefit Programs that are "excepted benefits" under HIPAA). You should review your insurance certificate and check with the Plan Administrator if you have questions about enrolling in a Benefit Program.

- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).
- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after coverage ends under Medicaid or a state CHIP.
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

You will need to provide documentation of your special enrollment event in order to enroll outside of an initial or annual open enrollment period. Contact the Plan Administrator to determine what information you will need to provide.

Code Section 125 Status of Plan

This Plan is designed and administered in accordance with Section 125 of the Internal Revenue Code and underlying regulations. This enables you to pay your share of premiums for certain Benefit Programs on a pre-tax basis, as permitted by the Employer. Review your election and enrollment materials to determine which Benefit Programs permit pre-tax premium payments and are subject to the Section 125 rules. Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld (and, in most states, before state taxes are withheld). This gives your contributions a special tax advantage and lowers the actual cost of

participating in the Plan to you. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections for Section 125 benefits. Generally, your elections stay in effect for the Plan Year (or other 12-month period of coverage for an insured benefit, as designated in your enrollment materials and election form) and you can make changes only during an annual open enrollment period. However, depending on the Plan's rules for mid-year election change events, you may be able to change your elections if a permitted election change event occurs as described below.

Permitted Mid-Year Election Change Events

The elections you make under the Plan are generally irrevocable during the Plan Year (or other 12-month coverage period that applies to a Benefit Program, as indicated in your enrollment and election materials). This means, for example, that once you have elected how much pre-tax income you will use to pay for the Plan's Benefit Programs, you are locked into that election until the next annual enrollment period. However, there are certain limited situations that allow you to change your Plan elections outside of the annual enrollment period, depending on the Plan's eligibility rules for a Benefit Program. You may change your elections if a "permitted election change event" occurs and you make an election change that is consistent with the event, as determined by the Plan Administrator.

This Plan allows participants to change their elections to extent permitted by applicable law and approved by the Plan Administrator. Depending on the Plan's eligibility rules for a Benefit Program, a "permitted election change event" that may allow you to change your election includes the following events:

- a change in your legal marital status, including marriage, divorce, death of spouse, legal separation or annulment
- a change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent
- a change in employment status for you, a spouse or a dependent that affects eligibility
- a change in a dependent child's eligibility
- a change in residency that would impact eligibility (for example, moving out of a plan's coverage area)
- the cost of a Benefit Program significantly changes
- coverage under a Benefit Program is significantly curtailed or ceases
- a new Benefit Program or other coverage option is added or coverage under an existing Benefit Program is significantly improved
- your spouse's or dependent's plan has a different enrollment period and you need to make a change to account for that other coverage
- you, your spouse or your dependent loses group coverage sponsored by a governmental or educational institution
- your change corresponds with a HIPAA special enrollment right (described above)
- you, a spouse or dependent is eligible for COBRA continuation coverage under the Plan (if applicable) and you need to increase your payments for the coverage
- a court order, such as a QMCSO or NMSN, mandates coverage for an eligible dependent child
- you, a spouse or a dependent enrolls in Medicare or Medicaid

- you take a FMLA leave (if applicable)
- a change in your employment status to less than full-time (for family coverage for most employee groups) or less than 30 hours of service per week on average (for employee-only coverage for most groups) even if the reduction does not result in loss of Plan eligibility
- eligibility for a special enrollment period to enroll in a qualified health plan (QHP) through the Marketplace or seeking to enroll in a QHP during the Marketplace's annual open enrollment period
- any other election change event recognized by the IRS and permitted by the Plan Administrator

Also, if the cost of a Benefit Program changes by an insignificant amount during a coverage period, the Plan Administrator may automatically make a corresponding change to your election. You should report an election change event to the Plan Administrator as soon as possible, but no later than 30 days after the event occurs. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day you are actively employed, unless benefits are extended, such as when you take an approved leave of absence.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins.

Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.

Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Dental
- Vision

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer's benefits booklets. You will automatically receive identification cards for you and your enrolled dependents when your enrollment is processed.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost.

You may choose from several types of medical plans or programs of benefits under this Plan, including:

- an HMO (Health Maintenance Organization)
- a PPO (Preferred Provider Organization)
- an HDHP with HRA (High Deductible Health Plan with Health Reimbursement Arrangement)

When you use network providers, the Plan pays the negotiated amount of covered expenses (after meeting any deductible) to your provider and there are no claim forms to complete. Certain medical options, such as an EPO or HMO, require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Certain medical options, such as an HMO or POS, may require you to select a primary care physician ("PCP") to coordinate your care. If so, you may designate any PCP who participates in the network and who is available to accept you or your family members. For dependent children, you may designate a pediatrician as the PCP. You do not need prior authorization from the Insurer or your PCP to obtain access to obstetrical or gynecological care from a network professional who specializes in obstetrics or gynecology. The network professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a PCP, and for a list of participating primary care physicians, contact the Insurer at the telephone number or website shown on your identification card.

Members of each employee group has access to a dental and vision benefit under this plan. Depending on the applicable collective bargaining agreement or employee handbook, you may participate in a dental and vision plan of the following types:

- a DPPO (Dental Preferred Provider Organization)

- a VPPO (Vision Preferred Provider Organization)

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network dental care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on a pre-tax basis.

Opt-out Incentive

There is an opt-out incentive available for eligible employees who waive health care coverage under the Plan. For more information on this incentive, including the eligibility rules, amount of incentive and payment terms, see your enrollment materials, the applicable collective bargaining agreement, or contact the Plan Administrator.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

Your Health Reimbursement Arrangement ("HRA")

Your medical plan may include an HRA, which is an arrangement funded entirely by the Employer. The purpose of the HRA is to reimburse you, up to certain limits, for you and your covered dependents' eligible out-of-pocket health care expenses, as explained below. Reimbursements paid by the HRA generally are excluded from taxable income.

How the HRA Works

Once you enroll in coverage, the Employer will establish an "HRA Account" in your name to keep a record of the amounts available to you for reimbursement of eligible health care expenses. This account is merely a recordkeeping account; it is not funded nor does it accrue earnings or interest of any kind. Reimbursements are made from the general assets of the Employer.

Before the start of each Plan Year, the Employer will determine the amount that may be credited during that Plan Year to your HRA. This amount will be shown in your enrollment materials. You do not contribute any money to the HRA.

The total annual Employer contribution amount will be credited to your HRA Account on your first day of coverage. If you first enroll in coverage during annual enrollment, your HRA funds will be available for reimbursement the first day of the next Plan Year.

Your HRA will be reduced by any amount paid to you, or for your benefit, for eligible health care expenses. The amount available for reimbursement as of any given date will be the total amount credited to your HRA as of such date, reduced by any prior reimbursements made to you. You may submit eligible expenses that you incur during a coverage period. Expenses are incurred when the service is performed or received.

Your HRA may only be used to reimburse the annual deductible for you and your covered dependents under the Plan. Your HRA may be used to reimburse Coinsurance expenses. Your HRA cannot be used to reimburse dental and vision expenses.

You receive a new Employer contribution each year you remain a participant in the HRA option. Any unreimbursed amount will be forfeited at the end of the coverage period.

You have the opportunity to opt out of and waive future reimbursements from the HRA at least annually. Contact your Employer for more information on opting out of the HRA.

How to Use Your HRA

When you incur eligible medical expenses during a coverage period, reimbursement may be made from your available HRA balance. There are a few possible reimbursement methods for HRAs. The methods that are available to you depend on how the HRA is administered. These methods may include, for example, having participants submit their own reimbursement requests to the Claims Administrator after eligible medical expenses are incurred, allowing participants to use an HRA debit card with qualified providers or using an automatic claims submission process managed by the health insurer or a third party administrator. Not all of these reimbursement methods may be available to you. If your health plan include an HRA, upon enrollment, your Employer will provide you with more specific information on how your HRA reimburses eligible medical expenses.

Your HRA can only be used to reimburse eligible medical expenses incurred by you (or your eligible dependents, if applicable). In some circumstances, the Claims Administrator may ask you to provide additional documentation to show that a medical expense is eligible for reimbursement. If you do not provide this information or if the Claims Administrator otherwise determines a reimbursement was improper, the Claims Administrator may take steps to correct the improper payment (including, for example, asking you to repay the full amount of the improper payment or deducting the improper payment from future HRA reimbursements).

Maintaining Records

You should keep all receipts to document expenses reimbursed to you from the HRA. If a payment must be verified at a later date, the Claims Administrator may request receipts from you to ensure that payment was made for a qualified expense. If a claim for benefits is denied, you have the right to appeal (see “Claims Procedure” for additional information) with the Claims Administrator.

Changes in Coverage

If you have a change in family status during a coverage period, your HRA balance will be adjusted automatically to reflect your coverage change. This adjustment will recognize amounts already reimbursed to you during the coverage period. This may result in a reduction or increase to your HRA balance, depending on your status change. For example, if you were receiving an Employer contribution based on coverage for yourself and one dependent, your HRA balance will be reduced if your covered dependent becomes ineligible for coverage mid-year.

Changes to your HRA balance will typically be made the first of the month following a qualified status change. If you have questions regarding how a change in status affects your HRA balance, contact the Claims Administrator.

When Participation Ends

Your participation in the HRA ends when you terminate employment. You may continue to access your HRA balance as described below.

If you terminate employment, your available HRA balance can be used only for eligible expenses incurred before the date of your termination. Any remaining amounts will be forfeited.

If your Employer is covered by COBRA and your health coverage ends due to a COBRA qualifying event, you will be given the opportunity to enroll in COBRA continuation coverage and elect an HRA medical option. If you elect COBRA for an HRA medical option, you can continue to use your remaining HRA balance to pay for eligible expenses and you will be eligible for the HRA accruals that similarly situated non-COBRA participants receive during your period of COBRA coverage. When you enroll in COBRA, your COBRA premium will include an amount to continue your HRA. You will be provided with more information on your COBRA coverage options if you experience a qualifying event.

However, the Employer’s contribution and your HRA balance may change if your level of coverage changes as described above.

If you die, claims may be submitted by your spouse or estate for eligible expenses incurred before your date of death, up to your available HRA balance.

Health Care Flexible Spending Account and HRA

The HRA is different from a Health Care Flexible Spending Account even though both may reimburse similar expenses. If you participate in both a Health Care Flexible Spending Account and an HRA, eligible expenses will be first reimbursed as described in your enrollment materials.

For More Information

For additional information about your HRA, contact the Claims Administrator or refer to your enrollment materials.

Your Health Savings Account ("HSA")

Your medical coverage may enable you to establish an HSA. To be eligible for an HSA, you must:

- Be covered by a high deductible health plan ("HDHP");
- Not be covered by other health coverage that is not an HDHP (with some limited exceptions);
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person's tax return.

To establish an HSA, you will need to open an account at an approved financial institution which will be used to pay for current and future health care expenses. Anyone can contribute to your HSA on your behalf, including a family member, your Employer or yourself.

How Your HSA Works

An HSA works in conjunction with an HDHP. Your HDHP will cover your eligible health care expenses after you meet your deductible. You can use your HSA to pay for eligible medical expenses until you meet your HDHP's deductible, or you can use your HSA to pay for qualified medical expenses not covered under your HDHP (for example, dental or vision expenses).

The HSA is not a part of the HDHP and is not sponsored by your Employer. The information in this section is provided only as an overview of the HSA benefit.

Your HSA can provide a triple tax advantage—contributions, investment earnings and amounts distributed for qualified medical expenses are all exempt from Federal tax and most state income taxes.

HSA Contributions

After you open your account, you (or anyone else on your behalf) can make contributions to your HSA. Unless indicated otherwise in your enrollment materials, you can make your HSA contributions by personal check and then deduct your contributions on your Federal income tax return. If you are allowed to make pre-tax salary reduction contributions to your HSA, that information will be included in your enrollment materials.

Although it is not the case on the effective date of this JCISD Summary Plan Description, an employer may contribute an annual amount (as shown in your enrollment materials) to your HSA. This amount may be a flat dollar amount payable to all participants or it may be based on the coverage you select (for example, self-only or family coverage). Employers are not required to make HSA contributions. If your enrollment materials do not show an Employer contribution, this means that your Employer does not contribute toward your HSA.

Because of an HSA's powerful tax savings, there are strict limits on how much can be contributed to your HSA each year. The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have, your age, the date you become an eligible individual and the date you cease to be an eligible individual. All contributions to your HSA for a calendar year (including contributions you, your Employer or anyone else makes on your behalf) are counted toward the HSA contribution limit.

In addition, if you are age 55 or older, you are permitted to make a $1,000 "catch-up" contribution to your HSA each year.

You may wish to discuss your individual tax situation with your tax advisor or obtain IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans, available at www.irs.gov.

Using Your HSA

You can receive tax-free distributions from your HSA to pay (or be reimbursed) for qualified medical expenses you incur after you establish your HSA. You can use your HSA account to pay for current and future qualified health care expenses. These include medical and prescription drug expenses, as well as deductible and coinsurance amounts, for yourself and your eligible dependents. A list of qualified medical expenses may be found in IRS Publication 502, available at www.irs.gov.

You will receive information about how to use your HSA when you open your account. Depending on where your account is, you may be issued a debit card or checkbook to pay for eligible expenses. It is important for you to keep receipts in order to document expenses for any tax year that may come under review.

You do not have to make distributions from your HSA each year. Unlike some other types of medical savings accounts, your HSA account balance rolls over from year to year.

If you use the money in your HSA for non-qualified medical expenses, the amount is subject to ordinary income tax, plus a 20-percent tax penalty if you are under age 65. The tax penalty generally does not apply if the distribution occurs after you reach age 65, become disabled or die; however, ordinary income tax will still apply.

Important Information about your HDHP/HSA

Participation in an HDHP/HSA is subject to the following IRS requirements:

- Your medical and prescription drug expenses are combined toward meeting your deductible—there is not a separate deductible for prescription drug expenses. This means that you have to pay the full cost for prescriptions, as well as medical expenses, until you have paid the HDHP's applicable deductible amount (individual or family). Then, the plan starts to pay. However, your HDHP may provide preventive care benefits without a deductible.
- You cannot be enrolled in other medical coverage (including a plan through your spouse's employer) that is not an HDHP, even as a dependent. However, you can participate in certain permissible types of coverage, such as a limited-purpose HRA or health FSA that reimburses or pays for dental and vision expenses.
- You cannot be enrolled under your spouse's non-HDHP coverage. However, you can still be an eligible individual even if your spouse has non-HDHP coverage, provided you are not covered by that plan.
- You cannot be enrolled in Medicare coverage.

For additional information about how an HDHP/HSA works, refer to IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans.

When Your HDHP Participation Ends

Your HSA belongs to you. It stays with you when you change employers or leave the workforce. If your medical coverage under the Plan terminates for any reason, the funds in your HSA account remain yours. Your HSA is also inheritable. What happens to your HSA when you die depends on who you name as your beneficiary. You will need to designate a beneficiary when you open your HSA.

You can make tax-free contributions to your HSA if you participate in another HDHP (and meet the other requirements for HSA eligibility). You may continue to use your HSA to pay for qualified medical expenses, or you may elect to leave the money in your account grow on a tax-free basis to use for future health care expenses. However, once you enroll in Medicare or are no longer covered by an HDHP, you are not permitted to make contributions to your HSA.

You may use your HSA funds to pay Medicare premiums. Payment of Medicare premiums is a qualified expense and a tax-free distribution. If you are 65 or older, HSA distributions used for

non-qualified medical expenses will be subject to ordinary income tax but exempt from the additional penalty tax.

Additional Information

For additional information about your HSA, contact the financial institution where your account is established. Since the rules governing HSAs are complex, you may also wish to obtain a copy of IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans.

Your Life and Accidental Death & Dismemberment ("AD&D") Coverage

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Group Term Life Insurance
- Voluntary Life Insurance (supplemental and/or dependent life)
- AD&D Insurance
- Voluntary AD&D Insurance (supplemental and/or dependent AD&D)

Participation

You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic. Any voluntary options available to you and the associated costs are described in the materials provided by the Insurer. Each year during the annual open enrollment period, you will be given an opportunity to elect or change your voluntary coverage, or confirm that your existing coverage is to be maintained for the following year.

Benefits Provided

The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

Source of Payment

Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts. The Company pays the full cost of your basic coverage. You are not required to make any contributions. The amounts of voluntary coverage available and, if applicable, any premiums for coverage will be shown on your Election Form when you enroll and will automatically be deducted from your pay.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

Coverage Continuation

If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy. You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.

Your Disability Benefits

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Voluntary Short-Term Disability (STD) Benefits – Employee paid
- Long-Term Disability (LTD) Benefits – Employer paid

Participation

If you wish to elect *voluntary STD* coverage, you must enroll in coverage after you meet all eligibility requirements. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary STD coverage will be shown on your Election Form when you first enroll in the Plan. Coverage becomes effective the first day of the benefit plan year (or the first of the month following your date of enrollment, if mid-year election is available). Each year during the annual open enrollment period, you will be given an opportunity to elect or change your coverage, or confirm that your existing coverage is to be maintained for the following year. If you decline STD coverage and later wish to re-enroll, you may need to provide evidence of good health to the Insurer before coverage is approved.

Your *LTD* coverage begins after you satisfy all eligibility requirements for coverage. Enrollment is automatic - no action is required on your part other than completing an application where required. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable.

Benefits Provided

Your Certificate of Insurance defines when you are considered disabled. Generally, you are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation due to physical disease, injury, or similar disorders.

Depending on your employee group, you may voluntarily enroll in a STD benefit that:

- provides 66% of your pre-disability pay, up to a maximum weekly benefit of $1200, for a maximum of 13 weeks, provided you continue to be disabled, with benefits beginning after 7 continuous days of illness, hospitalization or surgery, or immediately for an accident or injury; or
- provides a weekly dollar benefit ranging from $20 to $700, not exceeding your regular weekly salary, for a maximum duration of 52 weeks, provided you continue to be disabled; participants may choose a waiting period of 7 or 28 days continuous days.

LTD benefits are payable following an elimination period of 90 days. LTD benefits are currently 66% of your base pay. The maximum LTD monthly benefit payable varies by employee group, but the maximum monthly for the JIEA plan is $4,600 and for the non-union plan is $7,334.

You must be under the direct and continuous care of a licensed physician throughout the period for which disability benefits are paid. In order to continue receiving benefits, you are required to submit evidence, as requested, to support your disability claim. You may also be required to apply for Social Security disability benefits during the fifth month of your disability and, if necessary, appeal a denied claim.

Source of Payment

All disability benefits described above are paid by the Insurer and are guaranteed under the applicable insurance contract(s) or policies.

Payment of Benefits

Your STD benefit will be subject to tax withholding, FICA and other authorized payroll deductions if you elect to pay for premiums on a pre-tax basis. If you elect after-tax premiums, the STD benefit payable to you will not be subject to Federal withholding tax but may be subject

to other authorized deductions. Benefit payments will be made for each disability period. A successive period of disability due to the same or related causes will be considered as one continuous period of disability unless it is separated by a return to active employment as described in your Certificate of Insurance.

Generally, any portion of your LTD benefit paid with pre-tax or employer premium contributions will be taxable to you.

The Insurer is the Claims Administrator and is authorized to handle the day-to-day administrative tasks and pay claims. The Insurer may obtain the services of a licensed physician who will have the full authority and discretion to determine whether an absence is due to the same or related condition.

Offset of Other Benefits

If you become eligible for any disability benefits under state law or disability fund, Workers' Compensation, the Jones Act or any similar laws, state or Federal government income benefits (excluding military pensions), any self-insured, group, or individual pension plan to which the Employer contributes, or if you become entitled to Social Security disability benefits, your disability benefits may be reduced by the amount of benefits you receive, or are entitled to receive, as the result of your disability.

Limitations and Exclusions

No benefits will be payable for any period in which: 1) you engage in any occupation or perform any work for compensation or profit, except approved rehabilitative employment; 2) you are not under the continuous care of a licensed physician; or 3) you are determined not to be disabled.

You should refer to the materials provided by the Insurer for information concerning any additional limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, taxability of benefits, age reductions, or reductions for other benefits that may apply.

Claims and Appeals

If your claim for disability benefits is denied, you have the right to file an appeal with the Insurer, as described in your Certificate of Insurance and other materials provided by the Insurer. If your claim for benefits is denied, the Insurer will send you written notice of denial which will include the reasons for the decision and other supporting information used to make its decision. Any appeal of a denied claim must be filed within the required time frames specified in the group policy and your Certificate of Insurance.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your disability coverage.

Health Flexible Spending Account ("FSA")

The FSA is fully insured and administered by the Company listed in Appendix A. Eligible employees may elect to have a portion of their pre-tax income withheld and placed in a FSA, from which they can later request reimbursement for IRS-approved medical, dental and vision expenses that you would otherwise have to pay (i.e., they are not reimbursable from another source, like your insurance company) with after-tax dollars. Your year-end W-2 form will not reflect any contributions for purposes of federal, state or social security taxable wages.

Participation

To become a participant in the FSA Benefit Program, you must meet all eligibility requirements and enroll in coverage. Your dependents are not eligible for coverage. Employees who have coverage through a HDHP with a Health Reimbursement Arrangement are not eligible during that time period to participate in the FSA.

Benefits Provided

The benefits provided under the FSA Benefit Program are more fully described in the materials provided to you by the program administrator. In essence, employees can be reimbursed up to the maximum dollar amount they commit to have withheld during the plan year for out-of-pocket expenses, such as co-pays, deductibles, and co-insurance percentages. Please note, to be eligible for reimbursement the employee needs to have incurred eligible expenses and provide the proof of payment, but it is not necessary that the employee has already had the full requested amount already payroll deducted as of the date of the claim. The commitment to have the full amount deducted during the calendar year is sufficient.

Grace and Run Out Periods

The Plan allows a grace period to incur eligible health care expenses, to be paid from a balance in the employee's FSA: expenses must be incurred and paid for by March 15 of the following year. The Plan also requires claims for all eligible expenses, including both those incurred during the previous plan year and those incurred during the grace period, be submitted for reimbursement no later than March 31 ("run out period").

In order to take advantage of the grace period to incur reimbursable claims, you must be (a) a participant in the health FSA account on the last day of the plan year to which the grace period relates, or (b) a qualified beneficiary who is receiving COBRA coverage under the health FSA on the last day of the plan year to which the grace period relates. Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the plan year to which the grace period relates, and then from any amounts that are available to reimburse expenses incurred during the current plan year. The Plan Service Provider may reorder submitted claims to maximize a participant's reimbursement, therefore claims incurred during the grace period and/or payments may be reassigned to the current plan year.

If an employee terminates employment and participation in the health FSA, the employee can submit claims for expenses incurred while the employee remained a participant for up to 105 days after termination of employment (or loss of eligibility to participate).

Source of Payment

Benefits under the program are paid by the administrator and are guaranteed to the amount you authorize to be withdrawn from your paychecks as part of your open enrollment elections. You will authorize a specific deduction amount that will be applied to all of your paychecks during the plan (calendar) year. The entire balance of your account will be paid if you submit eligible expenses incurred during the defined plan year by the deadline March 31 of the following year ("run out period"). However, if you do not submit eligible expenses for reimbursement by the deadline, the funds left in your account will be forfeited.

Limited Scope Option

Employees may elect during the initial enrollment and/or annual enrollment period the limited scope option of reimbursement under the health FSA, so that the employee and/or a spouse may participate in a Health Savings Account associated with a HDHP, as defined in Code Section 223. Similarly, employees may elect during the initial enrollment and/or annual enrollment period to exclude the spouse from coverage under the health FSA so that the spouse may participate in a Health Savings Account associated with the spouse's HDHP.

Plan Limitations and Exclusions

The maximum amount of this benefit for 2017 is $2550, and the IRS may adjust this limit from time to time. The Employee Benefit Plan will raise the maximum FSA benefit amount to match the limit established by the IRS for the applicable plan year.

For More Information

If you have any questions about the FSA Benefit Program, you should consult your open enrollment materials or other materials provided by the FSA Plan Administrator.

Dependent Care Reimbursement Account ("DCRA")

The DCRA allows employees to elect to reimburse themselves with pre-tax deductions for eligible child care and elder care expenses that are incurred during the benefit plan (calendar) year. It works similarly to the Health FSA in that the employee elects during open enrollment to make a specific pre-tax dollar deduction from each paycheck during the year, which is held in an account for future reimbursement claims for eligible expenses. Unlike the Health FSA, however, these claims must be for dependent care expenses that have already been incurred and the account will only pay the claims when you have saved enough to cover the claims submitted.

Run Out Period

The Plan allows a "run out" period to claim eligible DCRA expenses, to be paid from a balance in the employee's DCRA: expenses must be incurred and paid for by December 31 of the plan year. The Plan also requires claims for all eligible expenses be submitted for reimbursement by employees who are active on December 31 no later than March 31 ("run out period").

The terminated employee may submit claims for expenses incurred while actively employed and a participant in the plan for 105 days after the employee terminates employment or participation.

Plan Limitations and Exclusions

The maximum amount for this benefit for 2017 is $5,000 for married filing jointly or single, and $2,500 for married filing separately. The IRS may adjust this limit for future years. The Employee Benefit Plan will raise the maximum DCRA benefit amount to match the limit established by the IRS for the applicable plan year. The maximum annual reimbursement the employee may claim during the year is the annual reimbursement amount elected by the employee on his salary reduction agreement, not to exceed the IRS maximum, above.

Source of Payment

Benefits under the program are paid by the administrator and are guaranteed to the amount you authorize to be withdrawn from your paychecks as part of your open enrollment elections. You will authorize a specific deduction amount that will be applied to all of your paychecks during the plan (calendar) year. The entire balance of your account will be paid if you submit eligible expenses incurred during the defined plan year by the deadline March 31 of the following year ("run out period"). However, if you do not submit eligible expenses for reimbursement by the deadline, the funds left in your account will be forfeited.

For More Information

If you have any questions about the DCRA Benefit Program, you should consult your open enrollment materials or other materials provided by the Plan Administrator.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is a Federal law that is applicable to health benefit plans of private employers. *The JCISD is not subject to ERISA*, but this Summary Plan Description is issued using ERISA guidelines. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

Jackson County Intermediate School District is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Benefit Plan Administrator
Jackson County Intermediate School District
6700 Browns Lake Rd
Jackson, MI 49201
517-768-5200

Following the guidance provided to private employers under ERISA, the JCSID Benefit Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is January 1 through December 31.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine how the policy year impacts your benefits.

Type of Plan

This Plan is a called a "welfare plan." ERISA includes group health plans under this definition; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 38-1710621 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

Insurers/Claims Administrators

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

It is important to understand that if the terms of this SPD conflict with the terms of the insurance certificate regarding substantive rules for an insured Benefit Program (such as benefits and

claims procedures), the terms of the insurance certificate will control, unless otherwise required by law.

Medical/Prescription Drug Benefits

Blue Care Network of Michigan
PO Box 68710
Grand Rapids, MI 49516-8710
800-662-6667
www.bcbsm.com

Blue Cross Blue Shield of Michigan
600 East Lafayette
PO Box 674416
Detroit, MI 48267
800-842-6965
www.bcbsm.com

MESSA
1475 Kendale Blvd.
PO Box 2560
East Lansing, MI 48826-2560
800-336-0013
www.messa.org

Dental Benefits

Blue Cross Blue Shield of Michigan
600 East Lafayette
PO Box 674416
Detroit, MI 48267
800-842-6965
www.bcbsm.com

Delta Dental
PO Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentalmi.com

Vision Benefits

Blue Cross Blue Shield of Michigan
600 East Lafayette
PO Box 674416
Detroit, MI 48267
800-842-6965
www.bcbsm.com

Vision Service Plan
PO Box 38508
Birmingham, AL 35238-5018
800-877-7195
www.vsp.com

Group Term Life Insurance Benefits

National Insurance Services, Inc.
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
800-627-3660
www.NISBenefits.com

Life Insurance Company of North America (through MESSA), a subsidiary of CIGNA
1601 Chestnut Street
Philadelphia, PA 19192-2235
215-761-1000
www.cigna.com

STD Benefits

National Insurance Services, Inc.
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
800-627-3660
www.NISBenefits.com

MESSA
Attn: Disability Department
1475 Kendale Blvd.
PO Box 2560
East Lansing, MI 48826-2560
800-336-0013
www.messa.org

LTD Benefits

National Insurance Services, Inc.
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
800-627-3660
www.NISBenefits.com

MESSA
Attn: Disability Department
1475 Kendale Blvd.
PO Box 2560
East Lansing, MI 48826-2560
800-336-0013
www.messa.org

Voluntary/Supplemental Life

National Insurance Services, Inc.
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
800-627-3660
www.NISBenefits.com

Life Insurance Company of North America (through MESSA), a subsidiary of CIGNA
1601 Chestnut Street
Philadelphia, PA 19192-2235
215-761-1000
www.cigna.com

FSA

EHIM
26711 Northwestern Highway, Suite 400
Southfield, MI 48033
248-204-6386
www.ehimrx.com

Agent for Service of Legal Process

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

Jackson County Intermediate School District
6700 Browns Lake Rd
Jackson, MI 49201
517-768-5200

Service of Legal Process may also be served on the Benefit Plan Administrator at the same address.

No Obligation to Continue Employment

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Nondiscrimination

The Plan is intended to be nondiscriminatory under Code Section 125. Code Section 125 prohibits discrimination in favor of highly compensated individuals with respect to eligibility to participate, highly compensated participants with respect to benefits and contributions and key employees with respect to total Plan contributions. If the Plan Administrator determines, at any time, that the Plan may fail to satisfy these nondiscrimination requirements, the Plan Administrator may take such action as it deems appropriate to comply with the nondiscrimination requirements. This action may include, for example, modifying the elections of highly compensated or key employees without their consent.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any representation, guarantee or warranty that any amount paid as premiums or distributed as benefits under the Plan will be excludable from your gross income for federal or state income tax purposes (or that any other state or federal tax treatment will apply or be available to you). It is your responsibility to determine whether payments are excludable from your gross income for federal and state income tax purposes.

Future of the Plan

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. A rescission of coverage is also considered an adverse benefit determination that triggers your right to file an appeal. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer's decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program's provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employer's plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules. Other than these disclosures, the Plan Sponsor will not create or receive PHI from the HIPAA Plans.

Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.

- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, contact the Plan Administrator.

Employee

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have questions regarding your eligibility for FMLA coverage or your state's family medical leave provisions, if applicable, contact your Employer.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of

the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

APPENDIX A: Benefit Program Information

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
GROUP MEDICAL INSURANCE HMO	BLUE CARE NETWORK OF MICHIGAN INSURER/CLAIMS ADMINISTRATOR	00118200-0001-0001	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL INSURANCE PPO	BLUE CROSS BLUE SHIELD OF MICHIGAN INSURER/CLAIMS ADMINISTRATOR	007004047-0002	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL INSURANCE HDHP + HRA	MESSA INSURER/CLAIMS ADMINISTRATOR	71453	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP DENTAL INSURANCE	BLUE CROSS BLUE SHIELD OF MICHIGAN INSURER/CLAIMS ADMINISTRATOR	007004047	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP DENTAL INSURANCE	DELTA DENTAL OF MICHIGAN INSURER/CLAIMS ADMINISTRATOR	0674-0011 0674-0011 0674-0012 0674-0013	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
GROUP VISION BENEFITS	BLUE CROSS BLUE SHIELD OF MICHIGAN INSURER/CLAIMS ADMINISTRATOR	007004047	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP VISION BENEFITS	VISION SERVICE PLAN INSURER/CLAIMS ADMINISTRATOR	71453	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP TERM LIFE INSURANCE BENEFITS	NATIONAL INSURANCE SERVICES, INC. INSURER/CLAIMS ADMINISTRATOR	3073 9417	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP TERM LIFE INSURANCE BENEFITS	LIFE INSURANCE COMPANY OF NORTH AMERICA INSURER/CLAIMS ADMINISTRATOR	FLI-980011	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
SHORT-TERM DISABILITY BENEFITS	NATIONAL INSURANCE SERVICES, INC. INSURER/CLAIMS ADMINISTRATOR	10297	September 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
SHORT-TERM DISABILITY BENEFITS	MESSA DISABILITY CLAIMS ADMINISTRATOR	LK-0980035	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
LONG-TERM DISABILITY BENEFITS	NATIONAL INSURANCE SERVICES, INC. INSURER/CLAIMS ADMINISTRATOR	6807	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
LONG-TERM DISABILITY BENEFITS • Negotiated • Employee Option	MESSA DISABILITY CLAIMS ADMINISTRATOR	LK-980031 FLK-0980020	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
VOLUNTARY/SUPPLEMENTAL LIFE	NATIONAL INSURANCE SERVICES, INC. INSURER/CLAIMS ADMINISTRATOR	3079 9417	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
VOLUNTARY/SUPPLEMENTAL LIFE	LIFE INSURANCE COMPANY OF NORTH AMERICA INSURER/CLAIMS ADMINISTRATOR	FLI-980012	July 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
FSA HEALTH AND DEPENDENT CARE	EHIM INSURER/CLAIMS ADMINISTRATOR	50001759-05	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

For Information Regarding Specific Benefits Refer To:

Medical Summary Benefit Coverages (SBC's)
Dental Plan Summary of Benefits
Vision Plan Summary of Benefits
Group Life Summary of Benefits
Voluntary Option Life Summary of Benefits
Short Term Disability Summary of Benefits
Long Term Disability Summary of Benefits

APPENDIX B: Marketplace Exchange Notice

Notice to All Employees (Marketplace Exchange Notice)

The federal government requires all employers provide the enclosed notice to all employees. We wanted to take a moment to explain the notice.

For individuals needing to purchase health insurance on their own, each State in the U.S. must have a new public Marketplace website and call center where individuals may shop for private health insurance. States are also integrating enrollment for Medicaid and the Children's Health Insurance Program (CHIP) into the public Marketplace to direct people into those programs if they qualify instead of purchasing private coverage.

Public Marketplaces are scheduled to be open for shopping October 1, 2013 for health insurance to begin 2014. Please note that insurance companies are not required to participate in the State's public Marketplace, so individuals are probably still not going to see all plans available in their community when shopping the public Marketplace.

As part of the new public Marketplaces, the Health Care Reform law also creates new federal tax credits to help pay for coverage. There are several requirements an individual must satisfy to qualify for these tax credits. One of those requirements is the individual cannot have access to employer-sponsored health insurance that meets the qualifying standards of the Health Care Reform law.

Your employer's plan will meet the government's qualifying standards. As a result, if you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You would pay full retail price for public Marketplace insurance (without the new tax credits)
    - You would no longer be paying for insurance on a pre-tax basis
    - You would no longer have an employer contribution toward your insurance
- You would navigate any questions you have directly with the insurance company you choose…HR will not be able to assist you with your public Marketplace plan
- Should you desire to come back to your employer's plan in the future, you will either need to experience a federally recognized "qualifying event" that allows a mid-year election change or wait until our next annual open enrollment

If you or someone in your household are not eligible for our plan and wish to apply for a public Marketplace tax credit, your *household* income must be within certain limits. When you apply for the tax credit, you will estimate your household income. If your household income ends up higher than you estimated, you may owe some or all of the tax credits back on your personal tax return.

The enclosed mandatory notice briefly explains what public Marketplaces are and how to access them.

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

(Employee Marketplace Exchange Notice)

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as Jan. 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

ADOPTION OF THE PLAN

Jackson County Intermediate School District
JCISD Employee Benefit
Section 125 Cafeteria Plan
Revised Adoption Agreement
Original Plan Effective Date: 10/1/2004
Revised Plan Effective Date: 1/1/2017

Item I – Adoption

The Employer hereby revises its qualified "Cafeteria Plan," which was established pursuant to Section 125 of the Internal Revenue Code effective 10/1/2004, and which was most recently amended effective 1/1/2014.

Item II – Employer Organization

Name of Organization:	**Jackson County Intermediate School District (JCISD)**
Federal Employer ID Number:	38-1710621
Address:	6700 Browns Lake Road, Jackson MI 49201
Phone:	517.768.5200
Organized in the State of:	Michigan

Item III – Plan Elections

Plan Number:	501
Plan Name:	Cafeteria Plan
Plan Year:	January 1 through December 31 (NOTE: This Plan is designed to run on a 12-month plan year, however a short plan year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.)
Plan Restated and Amended:	Effective 1/1/2017
Plan Administrator:	**Jackson County Intermediate School District**
Plan Service Provider:	**Employee Health Insurance Management, Inc. (EHIM)**
Address:	26711 Northwestern Hwy, #400, Southfield, MI 48033
Phone:	800.968.9682

EHIM, in conjunction with Plan Administrator JCISD, will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

Benefits Coordinator:	**Jackson County Intermediate School District**
Name:	Catherine Brechtelsbauer
Title:	Director of Human Resources & Legal Services
Address:	6700 Browns Lake Road, Jackson MI 49201
Phone:	517.768.5200
Acceptance of Legal Process:	**Jackson County Intermediate School District**
Name:	Catherine Brechtelsbauer
Title:	Director of Human Resources & Legal Services
Address:	6700 Browns Lake Road, Jackson MI 49201
Phone:	517.768.5200

COBRA Administrator:	**Employee Health Insurance Management, Inc. (EHIM)**
Address:	26711 Northwestern Hwy, #400, Southfield, MI 48033
Phone:	800.968.9682

Item IV – Eligibility Requirements

The Classification of eligible employees is All Employees *except* individual employees who fall into one or more of the following categories:

- Individuals under 18 years of age
- Employees who work less than 20 hours per week
- Employees who are employed less than nine (9) months per year

Service Period Requirement

The Service Period Requirement is the period of time that the Employee must be employed to be eligible to participate in the Plan. The Service Period Requirement for this Plan, unless an applicable insurance certificate states otherwise, is the first of the month following date of hire.

Plan Entry Date

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is after the Service Period Requirement is met.

Open Enrollment Period

The Open Enrollment Period will be during the month of November, with benefits effective January 1.

Item V – Benefit Package Options

Core Health and Other Insurance Benefits

The JCISD Benefit Plan differs by employee group. Eligible employees in each employee group are offered core health benefits including health insurance and dental and vision plans. A group long term disability benefit and term life insurance benefit are also available to eligible employees within each group. Employees are directed to review their collective bargaining agreements and plan descriptions available on the JCISD staff webpage for specific information about their core health benefit options. From year to year, these specific options may change, along with the benefit cost contributed by the employer and the employee; these adjustments are determined by state law, collective bargaining, change in availability of benefit options, and other factors.

Elective Benefit Options

The JCISD Benefit Plan offers eligible employees in each employee group to choose to pay for some elective benefit options, such as short term disability insurance and additional employee and dependent life insurance. The available options may change from time to time, and employees are encouraged to carefully review collective bargaining agreements and plan information provided during open enrollment.

Premium Conversion

The terms, conditions and limitations will be as set forth in and controlled by the Plan Document. Each year, each eligible participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participant in the plan, or during

the open enrollment period, as applicable, to make pre-tax contributions in order to pay the employee's required premium contribution for an employer-sponsored group health insurance plan.

Other Pre-tax Employee Benefit Contributions

The terms, conditions and limitations will be as set forth in and controlled by the Plan Document. Each year, each eligible participant may elect in writing on a form filed with the plan, or during the open enrollment period, as applicable, to make pre-tax contributions to a health flexible spending account and/or a dependent care reimbursement account in order to be reimbursed by the employer for eligible expenses incurred during that year by the employee.

Item VI – Incorporation by Reference

The actual terms and conditions of separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and the substantive content of the individual benefit plan documents will govern in the event of a conflict with the terms of the Employer's Summary Plan Description for the JCISD Employee Benefit Plans, adopted through this Agreement. It is also possible that JCISD could contract with a new Plan service Provider to perform identified Plan-related services. To that end, each separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

Approved by the JCISD Board of Education on April 25, 2017

Authorized Signature: /S/

Kevin Oxley, Superintendent
Jackson County Intermediate School District
6700 Browns Lake Road, Jackson MI 49201