BLUE SPRINGS R-IV SCHOOL DISTRICT

FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

07/01/2017

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INTRODUCTION

Blue Springs R-IV School District (the "School District") established the Blue Springs R-IV School District Flexible Benefits Plan (the "Plan") effective 07/01/1990. This summary describes the Plan as amended and restated effective 07/01/2017. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The School District and any employer who has adopted the Plan is referred to in this document as the "School District".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the School District or any affiliate who has adopted the Plan and you have attained at least 21 years of age.

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- Covered by a collective bargaining agreement that does not provide for participation in this Plan.
- A leased employee.
- A non-resident alien who received no U.S. source earned income.
- part-time seasonal employees under age 21.

If you are not eligible to participate in the School District-sponsored group health plan then you are not eligible to participate in the Health Flexible Savings Account.

If you elect to participate in the Health Savings Account (HSA) you are not eligible to participate in a Health FSA that is not an HSA-Compatible Health FSA.

If you are not eligible to participate in the School District-sponsored group health plan then you are not eligible to participate in the HSA-Compatible Health Flexible Spending Account.

If you elect to participate in the General Health FSA then you are not eligible to contribute to an HSA-Compatible Health FSA, unless you elect to convert your General Health FSA. You must be enrolled in a high deductible health plan to be eligible to participate in the Health Savings Account for the month. If you elect to participate in a General Health FSA for the Plan Year you are not eligible to participate in the HSA Benefit. If you are contributing to the General Health FSA as of the last day of a Plan Year, you cannot elect the HSA Benefit for any of the first three calendar months following the close of that Plan Year unless the balance in your General Health FSA is $0 as of the last day of the Plan Year. If you are not enrolled in a high deductible health plan you are not eligible to contribute to the HSA.

ELECTION PROCEDURES

If you are eligible to participate in the Plan on your date of hire, you may elect to participate in the Benefits under the Plan within 30 days after your date of hire (or a shorter period if established by the Plan Administrator). Your election will be effective as of your date of hire.

If you do not enroll in the Plan upon your date of hire, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you must submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator.

If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year. If you fail to submit an election form, prior year elections will automatically apply to the following benefits: Premium Conversion Account. An election to participate in the Plan is generally irrevocable for the Plan Year except for the HSA Benefit, described below. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.
- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the School District as permitted by applicable law.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to

determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your School District, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

Premium Conversion Account

The Plan will automatically establish a Premium Conversion Account in your name when you become an Employee for the payment of premiums under the School District-sponsored benefits/contracts listed below unless you affirmatively elect to not establish or contribute to such account. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- School District Health
- School District Dental
- School District Vision
- Cancer insurance and intensive care insurance

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA
- Limited Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

Limited Purpose Health FSAs may only be used to reimburse expenses incurred for qualifying dental or vision care or preventative care and are typically used in conjunction with a high-deductible group health plan. A Limited Purpose Health FSA is intended to qualify as an "HSA-Compatible Health FSA."

If you are eligible, you may elect to contribute to a Health FSA in accordance the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to

participate in the School District-sponsored group health plan, then you are not eligible to participate in a Health FSA.

You cannot participate in a General Purpose Health FSA and a Limited Purpose FSA simultaneously. If you elect to participate in the General Purpose Health FSA then you are not eligible to contribute to a Limited Purpose Health FSA, unless you elect to convert your General Purpose Health FSA as described below. Similarly, if you elect to participate in the Limited Purpose Health FSA you are not eligible to participate in the General Purpose Health FSA Benefit. Additionally, if you elect to participate in the Health Savings Account you are not eligible to participate in the General Purpose Health FSA Benefit.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code ($2,600 for 2017). The School District will not make additional contributions to your General Purpose Health FSA or your HSA-Compatible Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who may claim as a dependent on your federal tax return and also includes a child until his or her 26th birthday. The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA. Medicines or drugs are eligible expenses only if the medicine or drug is prescribed (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded).

You will not be reimbursed for any expenses that are (i) incurred before you are eligible to participate in the Health FSA, (ii) incurred after you have becomes ineligible to participate in the Health FSA and attributable to a tax deduction you take in a prior taxable year, or (iii) covered, paid or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

You must submit claims for reimbursement from your General Purpose Health FSA no later than 90 days after the end of the Plan Year. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the School District for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 90 days after the end of the Plan Year in which your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted

prior to this date have been processed.

Qualified Reservist Distributions

If you are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may elect to receive a distribution from your Health FSA up to an amount equal to Total amount contributed less amount reimbursed.. You must make the distribution request during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2017, $2500 if you are married and filing separately.)

The School District will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Plan Administrator or Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for himself/herself. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 90 days following the Plan Year. Any amounts remaining in your DCAP Account at the end of the Plan Year after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the School District for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 90 days after the end of the Plan Year in which your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

Health Savings Account (HSA)

A Health Savings Account may be used to reimburse qualifying medical expenses. If you are eligible, you may elect to contribute to an HSA in accordance with the "Election Procedures" described above.

HSA Eligibility

If, as of the first day of the month, you are enrolled in a high deductible health plan, you are eligible to participate in the Health Savings Account for the month. If you have elected to participate in a General Purpose Health FSA, you are not eligible to participate in the HSA. If you elected a Health FSA that had a balance on the last day of the previous Plan Year, you cannot elect to contribute to an HSA for any of the first three calendar months following the end of that Plan Year. If you are not enrolled in a high deductible health plan you are not eligible to contribute to an HSA.

HSA Contributions

Your HSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your HSA is the maximum amount permitted under the tax code ($3,400 for 2017, if you are enrolled in individual health coverage and $6,750 for 2017 if you are enrolled in family coverage).

The School District will not make additional matching contributions to your HSA on your behalf.

HSA Eligible Expenses/Reimbursement

Your HSA Benefit is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained outside the Plan. Consequently, the School District does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of your HSA contributions, but it will not create a separate fund or otherwise segregate assets for this purpose. The School District has no authority or control over the funds deposited in your HSA.

Termination of Employment

If you terminate employment with the School District for any reason during the Plan Year, your contributions to your HSA will end as of your date of termination. You will continue to be eligible to receive distributions from your HSA in accordance with the terms of the documents governing your HSA.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to Tri-Star Benefit Systems at:

Address: 16253 Swingley Ridge Road, Suite 210, Chesterfield, MO 63017
Phone number: 800-727-0182

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

To the extent that the Plan Administrator approves a claim, the School District may either (i) reimburse you, or

(ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of

the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and

(D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Claims Not Governed by this Summary

Benefits Provided under Contracts. Please see the underlying contracts for claims and reimbursement rules under those contracts.

HSA Claims. Claims relating to the HSA are administered by your HSA trustee/custodians in accordance with the HSA trust or custodial document.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your School District is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs at least 20 employees, but you should contact the Plan Administrator who can inform you if the School District is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of

the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."
If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice of your right to elect COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

Continuing Coverage

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if he or she is not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA

continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of his or her COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the School District no longer provides a Health FSA to any of its employees.

YOUR RIGHTS UNDER ERISA

As a participant in the Health FSA under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in a plan governed by ERISA shall be entitled to:

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

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

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for an ERISA welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court if you have exhausted the Plan's claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court if you have exhausted the Plan's claims procedures. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess

payments/reimbursements. You must also reimburse the School District for any liability the School District may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The School District may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The School District intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the School District does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Missouri to the extent not pre-empted by Federal law.

PLAN INFORMATION

1. The Plan Sponsor and Plan Administrator is Blue Springs R-IV School District.

2. The Plan Sponsor's and Plan Administrator's Address: 1801 NW Vesper, Blue Springs, Missouri 64015

3. The Plan sponsor's EIN is 446004932

4. The Plan Sponsor and Plan Administrator's phone number is 816-874-3200

5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.

6. The Plan number is: 501.

7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.

8. The Plan Year is the 12-consecutive month period ending on 06/30.

9. Amount contributed by Plan Participants and the School District to the Plan are general assets of the School District. All payments of benefits under the Plan are made solely out of the general assets of the School District. The School District has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The School District may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.