SUMMARY PLAN DESCRIPTION

of the

FLEXIBLE SPENDING PLAN

for

EMPLOYEES OF

BLOOMINGTON PUBLIC SCHOOL DISTRICT #87

(As amended and restated effective January 1, 2014)

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I. INTRODUCTION

The purpose of the Plan is to enable each Participant to establish a Flexible Spending Account. Through such an account, an employee of Bloomington Public School District #87 can purchase certain approved employee benefits with pre-tax dollars. Without a Flexible Spending Account, the same benefits could only be purchased on an after-tax basis. The cost of the benefits purchased through the Flexible Spending Account is thereby reduced by the amount of the taxes saved by the employee on the contributions to the Flexible Spending Account. Stated another way, since the dollars contributed to the Flexible Spending Account are unreduced by taxes, those dollars can purchase more benefits than the same dollars applied on an after-tax basis. Each employee decides how much, if any, that employee wants to contribute to the Flexible Spending Account.

This booklet contains a convenient summary of the Plan in ordinary language. It does not give full details nor does it cover all aspects of the Plan. The actual terms of the Plan are stated in the formal plan document which is the legal document governing all rights and benefits under the Plan.

You should read this booklet carefully to obtain a clear understanding of the benefits to which you may be entitled, as well as the circumstances that affect the availability of those benefits. Where a specific interpretation of the Plan is involved, or a provision of the Plan is related to a specific situation, you should consult the Plan Administrator. If there is any conflict between this Summary Plan Description booklet and the formal Plan, the terms and conditions of the Plan will govern. The Plan is available for inspection by participants and their beneficiaries upon request to the Plan Administrator.

II. ELIGIBILITY AND PLAN PARTICIPATION

1. Eligibility Requirements

You will be eligible to participate in the Plan when you satisfy the eligibility requirements for benefits under the terms of the Bloomington Public School District #87 Group Medical Plan. Eligibility for participation in the Flexible Spending Plan does not automatically qualify you for participation in the Group Medical Plan.

2. Participation

Your participation will begin on the first Participation Date which occurs on or after you have met the eligibility requirements. If you are absent from work due to (i) an FMLA Leave or (ii) a period of duty in the Uniformed Services you have the right to continue to participate in the Plan with respect to any benefit offered through the Plan that does not limit continued participation on the basis of a requirement that you remain actively at work. Your right to participate in the Plan while on a leave of absence is conditioned on you (i) continuing to have an employment relationship with the Employer, and (ii) making the required premium contributions, as provided in Article IV, Section 2 on Page 5.

III. DEFINITIONS

CHANGE IN STATUS: Those events which are contemplated or specified in the regulations accompanying Code Section 125, the occurrence of which will permit a Participant to revoke an existing election under the Plan and make a new election. Those events which are considered to be a "Change in Status" are limited to the following:

(1) An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(2) An event that changes a Participant's number of dependents (as defined in Section 152 of the Code), including birth, adoption, placement for adoption, or death of a dependent;

(3) Any of the following events that changes the employment status of the Participant, the Participant's spouse or the Participant's dependents: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if an eligibility condition of an employee benefit plan of the Employer of the Participant, spouse or dependent depends on the employment status of that individual and there is a change in individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that plan, then that change also constitutes a change in employment for purposes of the preceding sentence.

(4) A change in an individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that plan, if an eligibility condition of an Employee Benefit Plan of the Participant, spouse or dependent depends on the employment status of that individual.

(5) An event that causes a Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the accident or health plan under which the dependent receives coverage;

(6) A change in the place of residence or work of the Participant, spouse, or dependent; or

(7) An event that constitutes a special enrollment under the Health Insurance Portability and Accountability Act of 1996.

CODE: Internal Revenue Code of 1986, as amended from time to time.

DEPENDENT: For purposes of the Medical Reimbursement Plan, the term "dependent" means any person falling within the definition of dependent (as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) or child (as defined in Code Section 152(f)(1)) of the Employee who as of the end of the Plan Year has not attained the age of 27 years. For purposes of the Dependent Care Assistance Plan, the term "dependent" means any individual who is (a) a dependent of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an

exemption under Code Section 151, or (b) a dependent or spouse of the Participant who is physically or mentally incapable of caring for himself..

EFFECTIVE DATE: January 1, 2014, the date on which the provisions of this amended and restated Plan became effective.

EMPLOYEE: Means any person employed by Bloomington Public School District #87.

EMPLOYEE BENEFIT PLAN: Any health or welfare plan now or hereafter adopted by the Employer for the exclusive benefit of its employees, and, if so designated by the Employer, through which benefits are available under the Plan to its Employees.

EMPLOYER: Means Bloomington Public School District #87.

FMLA: Means the Family and Medical Leave Act of 1993.

FMLA LEAVE: Means a leave of absence that the Employer extends to an Employee under the provisions of the FMLA.

PARTICIPANT: An Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan.

PARTICIPANT ACCOUNT: An account maintained by the Employer for bookkeeping purposes to record each Participant's contributions and deductions for benefits as provided herein.

PARTICIPATION DATE: For Employees eligible to participate as of the Effective Date, participation shall commence as of the Effective Date. For Employees who become eligible to participate after the Effective Date, participation shall commence as of the date the Employee first satisfies the Eligibility Requirements specified herein. For Employees who do not elect to participate as of their initial Participation Date and who subsequently elect to do so, and for former Participants whose prior period of participation in the Plan had terminated for whatever reason, participation shall commence as of the first day of the next succeeding Plan Year following the Year during which the Employee made such election. For new Employees hired after the Effective Date, participation shall commence as of the later of (a) the date they satisfy the Eligibility Requirements, or (b) their date of hire.

UNIFORMED SERVICES: Means the U.S. Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

Year (or Plan Year): The 12-consecutive month period commencing on January 1 and ending on the next succeeding December 31.

IV. CONTRIBUTIONS

1. Participant Contributions

(a) Alternatives

Each Participant can choose, from among the available options, both the type of benefits that Participant wishes to purchase through the Plan and the amount of compensation the Participant wishes to defer into the Plan to be applied toward the purchase of those benefits.

(b) Election

Prior to the date you initially become eligible to participate in the Plan, and then prior to the beginning of each Plan Year thereafter, you must decide among the available alternatives as to the amount and type of benefits you wish to fund through the Plan. The Plan Administrator will assist you in making these elections and completing the required forms. Once you make an election as to the amount and type of benefit, you cannot change your election until the beginning of the next Plan Year, unless the change is requested due to a Change in Status as defined on page 2 or for one of the other reasons set forth below. In addition, you will not be permitted to change your election under any circumstances following your termination of employment until the end of the Plan Year during which your termination of employment occurs.

Changes due to a Change in Status can be made at any time, except that no changes will be permitted after your termination of employment for the balance of the Plan Year during which your participation continues. All changes due to a Change in Status must be consistent with that Change in Status as described in the formal plan document.

In addition to the above, a Participant may modify his election in the following respects:

(1) the Participant may increase his election to account for payment of COBRA continuation coverage under Code Section 4980B, or a similar state law, where the Participant has elected such continuation coverage;

(2) the Participant may change his election as a result of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Support Order) that requires the Participant or the Participant's spouse to provide accident or health insurance coverage for the Participant's child or foster child who is a dependent of the Participant;

(3) the Participant may change his election due to a change in the entitlement of a Participant, spouse or dependent to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (Pediatric Vaccines);

(4) the Participant may change his election due to FMLA Leave;

(5) the Participant may change his election due to a significant cost increase, significant curtailment, or termination of coverage or of a coverage option unless, in the case of a dependent care provider, the significant cost increase is imposed by a provider who is a relative of the Participant;

(6) the Participant may change his election due to a change in benefit options available under the health plan maintained by the Employer or a health plan maintained by another employer which affects the coverage of the Participant or the Participant's spouse or dependents.

(c) Application of Contributions

The value of any contributions you make to the Plan can only be used to purchase the benefits you have specified in your election forms or to offset the cost of administering the Plan.

2. Contributions by Employees on FMLA and Uniformed Service Leaves of Absence

You may elect to maintain coverage while on a FMLA Leave or leave of absence for duty in the Uniformed Services, but you must continue to make any required contributions specified in Article IV, Section 1 above. During the absence, you may choose to make these contributions by:

(a) remitting payment to the Employer on or before each pay period for which the contributions would have been deducted from your paycheck if leave had not been taken, provided that any delinquent payments must be made within thirty (30) days of their due date; or

(b) at your request, prepaying the amounts that will become due during the leave out of one or more of your paychecks preceding the leave.

If you are absent from work for any paid leave of absence, you must continue any and all benefits elected under this Plan not prohibited by any policy or program requiring you to be actively at work, and employee contributions for those benefits will continue to be deducted from your paychecks during the absence.

3. Eligibility For Other Employee Benefits

Participation in the Plan will not affect the calculation of your other employee benefits, such as life insurance and medical benefits or Code Section 403(b) plan benefits. However, it may affect the calculation of your Social Security benefits.

V. BENEFITS

As a participant in the Plan, you can choose among the following benefits:

1. Health Plan Premiums

The cost of premiums you are required to pay for coverage under the health plan. To the extent that you want health coverage, you may elect to pay the required premiums through the Plan.

2. Medical Expense Reimbursement

Any of the following types of expenses you currently pay toward the cost of your health benefits:

(a) the deductible and shared expenses you are required to pay under the terms of the health plan, and

(b) other expenses not covered under the health plan but which are nevertheless considered "medical care" under Code Section 213(d). Examples of qualifying expenses are included in the list attached hereto. This list is not intended to be comprehensive. You may incur other expenses not on the list but which nevertheless are considered "medical care" under the Code and therefore are eligible for reimbursement under the Plan.

For Plan Years beginning after December 31, 2012, the maximum amount that you can be reimbursed for medical expenses is limited by Code Section 125(i) (currently $2,500).

3. Dependent Care

The cost of dependent care expenses which you incur to permit you (and your spouse, if you are married) to work. Before electing this benefit, you should compare its effect with the effect of the child care credit available for federal income tax purposes. You can then choose the method of paying for dependent care that saves more tax dollars. This comparison must be made prior to your filing an election under the Plan, since the child care tax credit is not available for benefits paid through the Plan.

VI. CLAIMS

1. Claims for Benefits

Benefits which had previously been paid directly by the Employer, such as health insurance premiums, will continue to be paid in the same manner. It is not necessary that you file a claim to provide for payment.

You should file a claim for other benefits after you have incurred and paid these expenses. Claims must be filed on the proper forms, which can be obtained from the Employer. For reimbursement of medical expenses which are not covered under the health plan, you must submit an Explanation of

Benefits Statement in addition to the claim form. Claims for reimbursement under the Plan will be based on the amount of expenses that are denied under the Health Plan.

2. Payment of Claims

The Contract Administrator has been retained by the Employer to process claims. Claims will be processed on a continuous basis. Disbursements will be made by check payable to you. The following rules apply to the processing of all claims:

(a) (i) Dependent Care

If a claim or claims are filed which exceed the balance in your Participant Account, the claim or claims will be processed and you will receive partial reimbursement. The claim or claims will then automatically be reprocessed after each pay period and, to the extent that additional amounts have been deposited in your Participant Account, you will receive additional reimbursements until the claim is reimbursed in full or until the end of that calendar year, whichever occurs first.

(ii) Medical Expense Reimbursement

If a claim or claims are filed which exceed the balance in your Participant Account, a claim or claims will be processed and you will be reimbursed up to the maximum amount which you could contribute to your Participant Account, assuming that you had remained a Participant for the balance of that Plan Year. You will not be reimbursed for claims which exceed the maximum amount which you could contribute to the Plan assuming you had remained a Participant and continued to contribute at the same rate for the balance of that Plan Year.

(b) The Explanation of Benefits you receive with your expense reimbursement will also include the current balance in your Participant Account.

(c) You will receive quarterly summaries of your contributions and benefits for that quarter.

(d) You can only be reimbursed for claims which are filed for the same calendar year as the year during which the applicable expense was incurred, and for claims which are filed for the period ending on the fifteenth day of the third month following the end of that year.

3. Denial of Claim

If your claim for benefits is denied, the Plan Administrator will give you or your beneficiary a written answer explaining the specific reasons why the claim was turned down. The Plan Administrator may delegate all or part of the claim review procedure to the Contract Administrator.

4. Claims Review Procedure

(a) Written Denial

If a claim is denied or partly denied, you will be notified in writing and given an opportunity for review. The written denial will give:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for you to perfect the claim and explanation of why such material or information is necessary;

(4) An explanation of the Plan's claim review procedures, the time limits under the procedures and a statement regarding your rights to file a lawsuit under applicable state or federal law following an adverse benefit determination on appeal;

(5) If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request; and

(6) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request.

(b) Claims

If a claim is wholly or partially denied, the Contract Administrator shall notify you of the adverse decision within:

(1) a reasonable period of time, but no later than thirty (30) days after the Plan's receipt of the claim; or

(2) if the Contract Administrator determines that an extension of time for processing the claim is needed due to matters beyond the control of the Plan, the Contract Administrator shall notify you of the reasons for the extension and the extended due date before the end of the thirty (30) day period after filing the claim, and the extended period shall not exceed forty-five (45) days after the date of the filing of the claim.

If the extension is necessary due to your failure to submit specific information, the notice of extension shall describe the required information and you shall be given at least forty-five (45) days from receipt of the notice to submit the information. If additional information is requested, the time period for making a determination shall be tolled from the date on which notice is sent to the claimant until the date you respond to the request for additional information.

(c) Appeal of Adverse Benefit Determination

If a claim is wholly or partially denied, you, or your duly authorized representative, may request a review upon written application to the Contract Administrator. Any such request for a review must be mailed to the Contract Administrator within one hundred eighty (180) days after your receipt of a written notification of denial of a claim.

You may submit written comments, documents, records and other information related to the reviewed claim, and you shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the reviewed claim. A document is considered relevant to the claim if it: 1) was relied upon in making the benefit determination, 2) was submitted, considered or generated in the course of making the decision, or 3) demonstrates compliance in making the benefit decision with the requirement that the benefit determinations must follow the terms of the Plan and be consistent when applied to similarly situated claimants.

The review on appeal shall: 1) consider all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination, 2) shall not defer to the initial adverse benefit determination, and 3) shall not be conducted by the individual who made the initial adverse determination nor the subordinate of such individual.

In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug, or other item is experimental, investigation, or not medically necessary or appropriate, the plan fiduciary conducting the appeal review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination shall be identified without regard to whether the advice was relied upon in making the benefit determination.

A decision on a claim appeal shall be made by the Contract Administrator within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) days after receipt of a request for review from the claimant. The decision on review shall be in the form provided in Section (d) below.

(d) Content of Notice of Appeals Decision

A notice of benefit determination on appeal shall be in writing or electronic form and, if the determination is adverse, the notice will provide the following information:

(1) The specific reason or reasons for the adverse determination;

(2) Specific reference to pertinent Plan provision(s) on which the determination is based;

(3) A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim, as defined in (b) above;

(4) A description of any voluntary appeal procedures offered under the Plan, your right to obtain information about such procedures and a statement regarding your rights to bring a lawsuit under applicable state or federal law following an adverse benefit determination on appeal;

(5) If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request;

(6) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request; and

(7) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency."

5. Privacy Requirements

(a) Use and Disclosure of Protected Health Information

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

"Payment for health care" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the determination of benefits and adjudication of health benefit claims (including appeals and other payment disputes).

(b) The Plan will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With authorization from a Participant or Plan beneficiary, the Plan will disclose PHI to other employee benefit plans maintained by the Employer for purposes related to the administration of these plans.

(c) With Respect to PHI, the Plan Sponsor Certifies and Agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual;

(4) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual or allowed in accordance with Section (b) above;

(5) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) Make PHI available to an individual in accordance with HIPAA's access requirements;

(7) Make available the information required to provide an accounting of disclosures;

(8) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purposes for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

VII. GENERAL

1. Year End

Expenses incurred in your Medical Expense Reimbursement Account during a Plan Year, or during the period ending on the fifteenth day of the third month following the end of the Plan Year, can be reimbursed up to 90 days following the end of a particular Plan Year and still be deducted from your Participant Account for that year. Any balance remaining in your Participant Account after the 90-day period has expired is forfeited.

2. Termination of Participation

You may elect to discontinue participation in the Plan at the end of each Plan Year. You should ask the Employer or Contract Administrator about the correct procedure to terminate your participation. However, if you terminate your employment during the Year, the following rules apply:

(a) All benefits except Medical Expense Reimbursement account benefits

Your participation will not automatically stop upon your termination of employment during a calendar year. Once your employment terminates, you can continue to receive benefits under the Plan for the balance of the Plan Year during which your employment terminates, as long as there are still funds in your Participant Account.

(b) Medical Expense Reimbursement account benefits

If you terminate your employment during the calendar year, your election to participate in the Medical Expense Reimbursement Plan will terminate unless you elect to continue your participation in the Medical Expense Reimbursement Plan under COBRA. If you timely make this election and make all required contributions to the Medical Expense Reimbursement Plan, you can continue to receive benefits under the Plan for the balance of the Plan Year during which your employment terminates, as long as the total benefits claimed during the Year do not exceed the maximum amount which you can defer into the Plan for that Year. You may pay the required payments for such benefits on an after-tax basis or on a pre-tax basis out of your final paycheck or from available severance payments. Once you terminate employment, however, you will not be permitted to change your election due to a Change in Status.

3. Questions/Forms/Information

Any questions, requests for forms or other inquiries should be directed to Employer or the Contract Administrator.

4. Nondiscrimination

It is the intent of the Employer that the Plan not discriminate in favor of any Employee or group of Employees. If the Employer determines that the Plan is discriminatory, the Employer shall select and exclude from coverage under the Plan such Participants, or reduce the contributions and/or benefits of such Participants, as shall be necessary to comply with the nondiscrimination provisions of the Code.

Examples of Expenses Eligible for Reimbursement

Acupuncture
Artificial limbs
Birth control pills
Braille-books and magazines
Car controls for the handicapped
Care for mentally handicapped dependents
Chiropractors
Christian Science practitioner's fees
Crutches, wheelchairs, and similar equipment
Day care expenses for eligible dependents as necessary due to employment
Deductible and co-insurance amounts you pay for health or dental benefits
Dental expenses, including dentures and braces
Diagnostic and laboratory fees, x-rays
Eyeglasses or contact lenses, including examination fee
Hearing devices and batteries
Home improvements motivated by medical considerations
Hospital bills
Hypnosis for treatment of an illness
Laetrile by prescription
Lead-base paint removal (for children with lead poisoning)
Membership fees in association furnishing medical services, hospitalization and clinical care
Nurses' fees (including nurses' board and Social Security tax where paid by taxpayer)
Obstetrical expenses
Orthopedic shoes
Oxygen
Physician fees
Prescribed drugs and medical supplies
Prescribed over-the-counter drugs
Psychiatric care or psychologist fees
Routine physicals and other non-diagnostic services or treatments
Seeing-eye dog and its upkeep
Special education for the handicapped
Special plumbing for the handicapped
Sterilization fees
Surgical fees and related treatment
Telephone, special for deaf
Television audio display equipment for the deaf
Therapeutic care for drug and alcohol addiction
Therapy treatments
Transportation expenses primarily incurred in the rendering of medical service
Vitamins by Prescription

PLAN ADMINISTRATION

Employer/Plan Administrator:	Bloomington Public School District #87
Address:	300 E. Monroe Bloomington, IL 61701
Telephone Number:	(309) 827-6031
Employer I.D. Number:	37-1266265
Type of Plan:	Cafeteria Plan, adopted pursuant to Section 125 of the Internal Revenue Code
Plan Number:	010
Contract Administrator:	Benefit Planning Consultants, Inc. 2110 Clearlake Boulevard Champaign, IL 61822-8939
Telephone Number:	(217) 355-2300
Agent for Service of Legal Process:	William H. Campbell, Esq.
Address:	Davis & Campbell L.L.C. 401 Main Street, Suite 1600 Peoria, Illinois 61602
Telephone Number:	(309) 673-1681
NOTE:	Proper service can also be obtained by serving the Employer/Plan Administrator
Effective Date of Plan:	January 1, 1989
Effective Date of Plan Restatement:	January 1, 2014
Ending Date of Plan's Fiscal Year:	December 31