SAVANNAH-CHATHAM COUNTY PUBLIC SCHOOL SYSTEM

CAFETERIA PLAN (SECTION 125)

SUMMARY PLAN DESCRIPTION

January 1, 2018

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INTRODUCTION

Savannah-Chatham County Public School System (the "Company") established the Savannah-Chatham County Public School System Cafeteria Plan (Section 125) (the "Plan") effective 02/14/1996, amended the plan 01/01/2012. This Summary Plan Description describes the Plan as amended and restated effective 01/01/2018.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You (the responsible participant) are an "Eligible Employee" if you (the responsible participant) are employed by Savannah-Chatham County Public School System or any affiliate who has adopted the Plan. However, you (the responsible participant) are not an "Eligible Employee" if you (the responsible participant) are any of the following:

You (the responsible participant) are a temporary employee.

You (the responsible participant) are an employee with a classification of 0.50 or less and work less than 20 hours per week.

You (the responsible participant) are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you (the responsible participant) become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below; but only if you (the responsible participant) are not a self-employed individual (including a partner) and you (the responsible participant) are not a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation. The eligibility rules above also apply.

Date of Participation

You (the responsible participant) will become a Participant eligible to receive benefits from the Plan on the first day of the calendar month next following the date you (the responsible participant) attain age 18 and you (the responsible participant) complete 30 days of service as an Eligible Employee.

However, you (the responsible participant) will become a Participant eligible to make contributions and receive benefits from the Premium Conversion Account on the date you (the responsible participant) become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

You (the responsible participant) will stop being a participant eligible to receive benefits from the Plan on the date you (the responsible participant) are no longer an Eligible Employee or the date you (the responsible participant) terminate employment with the Company.

ELECTIONS

In General

When you (the responsible participant) become eligible to participate in the Plan, you (the responsible participant) may begin contributing to the Plan. All contributions will be credited to an account established in your behalf. Your contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you (the responsible participant) 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 (the responsible participant) should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Election Procedures

When you (the responsible participant) are first eligible to participate in the Plan, you (the responsible participant) must logon and make your election to the Plan Administrator on or before the date specified by the Plan Administrator. You (the responsible participant) will use the online/electronic enrollment system in place at the time to complete this function.

After you (the responsible participant) are first eligible to participate in the Plan you (the responsible participant) will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you (the responsible participant). In order to participate in the Plan for the next Plan Year, you (the responsible participant) must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you (the responsible participant) may modify elections at a time other than the beginning of a Plan Year.

If, as of the start of a Plan Year, you (the responsible participant) have not returned an election form by its due date, you (the responsible participant) will be deemed to have elected not to participate in the Plan for that Plan Year.

Modification of Elections

Generally speaking, you (the responsible participant) may only revise your elections as of the start of a Plan Year. However, in certain situations you (the responsible participant) may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you (the responsible participant)

have any questions or believe that you (the responsible participant) may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A 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.

Significant cost or other coverage changes.

You (the responsible participant) take leave under the FMLA

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

BENEFITS

Premium Conversion Account

When you (the responsible participant) become eligible to participate in the Plan, the Plan will establish a Premium Conversion Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. This account may be used to pay premiums on the contracts listed below:

Employer Group Medical *(This is a pre-tax benefit controlled by the State of Georgia Health Benefit Plan. Our responsibility for this plan is limited to taking pre-tax deductions only).*

Employer Dental

Employer Vision

Flexible Spending Account, Medical

Flexible Spending Account, Dependent Care

Voluntary Benefits

Other plans that might be added from time-to-time by the Board for the benefit of employees.

If a contract is offered in conjunction with a Company-sponsored benefit plan, you (the responsible participant) will be eligible to make contributions to the Premium Conversion Account only if you (the responsible participant) are also eligible to participate in the applicable Company-sponsored plan, it is described above and you (the responsible participant) are eligible to participate in this Plan.

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

Flexible Spending Account, Medical

When you (the responsible participant) become eligible to participate in the Plan, the Plan will establish a Flexible Spending Account, Medical in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You (the responsible participant) will be entitled to receive reimbursement from this account for eligible expenses incurred by you (the responsible participant), your spouse and dependents, if any. A dependent is generally someone who you (the responsible participant) may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. You (the responsible participant) may receive reimbursement for eligible expenses incurred at a time when you (the responsible participant) are actively participating in the Plan.

The entire annual amount you (the responsible participant) elect to contribute for the Plan Year for the Flexible Spending Account, Medical less any reimbursements already disbursed will be available for reimbursement. The maximum amount you (the responsible participant) may contribute each year is the maximum amount permitted ($2,650 for 2018).

Eligible expenses generally include all medical expenses that you (the responsible participant) may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Flexible Spending Account, Medical. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded). You (the responsible participant) will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you (the responsible participant) are eligible to participate in the Plan, (iii) attributable to a tax deduction you (the responsible participant) take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Effective January 1, 2012, if you (the responsible participant) are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you (the responsible participant) may receive a distribution from your Flexible Spending Account,

Medical. You (the responsible participant) must make the distribution 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. The entire amount you (the responsible participant) elected for the Flexible Spending Account, Medical for the Plan Year minus Flexible Spending Account, Medical reimbursements received as of the date of the Qualified Reservist Distribution request can be withdrawn.

Flexible Spending Account, Dependent Care

When you (the responsible participant) become eligible to participate in the Plan, the Plan will establish a Flexible Spending Account, Dependent Care in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You (the responsible participant) will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you (the responsible participant) incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you (the responsible participant) and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify if they allow you (the responsible participant) to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

Before and after school programs

Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)

Licensed child care center

Nursery school or pre-school

Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you (the responsible participant) will seek reimbursement will qualify as dependent care assistance.

You (the responsible participant) will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you (the responsible participant) are eligible to participate in the Plan, (iii) attributable to a tax credit you (the responsible participant) take for the same expenses, or (iv) covered, paid or reimbursed from any other source.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is $5,000 ($2,500 if you (the responsible participant) are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the

earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

You (the responsible participant) generally must file a Form 2441 to determine whether any part of your Flexible Spending Account, Dependent Care is taxable. Please note that participation in the Plan may prevent you (the responsible participant) from taking a tax credit for the same expenses. You (the responsible participant) should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you (the responsible participant) are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you (the responsible participant) may receive from the Plan.

FORFEITURES

Plan Year/Termination

Any amounts remaining in your account at the end of the Plan Year will be forfeited after all claims are paid. In addition, any balance remaining in your account on the date you (the responsible participant) terminate employment with the Company will be forfeited after all claims are paid.

CLAIMS

Deadlines

You (the responsible participant) must submit claims for reimbursement within 90 days after the end of the Plan Year. If you (the responsible participant) terminate employment, you (the responsible participant) must also submit claims for reimbursement within 90 days after the end of the Plan Year.

Debit Cards

The Company will provide you (the responsible participant) with a debit card for purposes of making purchases that may be reimbursed from your Flexible Spending Account, Medical and/or your Flexible Spending Account, Dependent Care. The Plan Administrator may provide you (the responsible participant) with more information about stored value cards at the time you (the responsible participant) enroll in the Plan. The following restrictions apply to the

use of such card: Standard Internal Revenue Service Guidelines apply to the use of the debit card.

Documentation of Claims

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.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company will reimburse your directly. The company will not reimburse other third party providers directly. The Plan Administrator will pay claims at least once per year, but typically, once per week. 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. The plan will make reimbursement by direct deposit, debit card, and manual check available to you (the responsible participant).

Where to Submit Claims

All claims must be submitted to the designated vender that is subject to change as needed:
Continuon Services, LLC at 1350 Spring Street, Suite 475, Atlanta, GA 30309. The telephone number is 1-877-747-4141.

Refunds/Indemnification

You (the responsible participant) must immediately repay any excess payments/reimbursements. You (the responsible participant) must reimburse the Company for any liability the Company 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 (the responsible participant) 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 under this Plan.

Beneficiary

If you (the responsible participant) 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 (the responsible participant) may designate a specific beneficiary for this purpose. If you (the responsible participant) 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.

Claim Procedures for Health Benefits *(This section does not apply; defer to each carrier policy regarding claim payments.*

Application for Benefits. You (the responsible participant) or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (5): (A) 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 adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination 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 the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's 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 shall:

(1) 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 adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part 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;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual 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 any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

Claim Procedures for Non-Health Benefits *(this section does apply and is applicable to Flexible Spending Accounts, Medical and Flexible Spending Accounts, Dependent Care)*

Application for Benefits. You (the responsible participant) or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written 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. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

The Plan Administrator will use the same review process that is outlined in the Sick Leave Bank policies and procedures for the purpose of handling appeals related to this benefit. The Superintendent’s decision becomes final after all appeals have been exhausted.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you (the responsible participant) serve in the United States Armed Forces and must miss work as a result of such service, you (the responsible participant) may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you (the responsible participant), your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you (the responsible participant). The Plan Administrator will inform you (the responsible participant) of these rights, if any, when you (the responsible participant) terminate employment.

FMLA

If you (the responsible participant) go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you (the responsible participant) may be able to continue receiving health care benefits.

You (the responsible participant) may elect to continue coverage on a pre-tax or after tax basis for non-medical benefits when on leave of absence under the FMLA.

If you are receiving a pay check, your deductions will continue to be withdrawn. If you are not receiving a paycheck, please contact the Human Resources department to understand the options available to you as soon as you are aware of your need to take leave.

Non FMLA Leave

In addition, you (the responsible participant) may elect to continue coverage on a pre-tax or after tax basis when on leave of absence **other** than the FMLA subject to the following limitations: Contact the Human Resources Department for more details.

YOUR RIGHTS UNDER ERISA ***(The District is not subject to ERISA, therefore this section is for informational purposes only.)***

As a participant, you (the responsible participant) are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you (the responsible participant) have the right 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 if a 5500 is required to be filed by the plan.

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 Plan 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 (the responsible participant) 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.

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

If your claim for a benefit is denied or ignored, in whole or in part, you (the responsible participant) 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 (the responsible participant) can take to enforce the above rights. For instance, if you (the responsible participant) request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you (the responsible participant) 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 (the responsible participant) up to $110 a day until you (the responsible participant)

receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you (the responsible participant) have a claim for benefits which is denied or ignored, in whole or in part, you (the responsible participant) may file suit in a state or Federal court. In addition, if you (the responsible participant) disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you (the responsible participant) may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you (the responsible participant) are discriminated against for asserting your rights, you (the responsible participant) may seek assistance from the U.S. Department of Labor, or you (the responsible participant) may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you (the responsible participant) are successful the court may order the person you (the responsible participant) have sued to pay these costs and fees. If you (the responsible participant) lose, the court may order you (the responsible participant) to pay these costs and fees, for example, if it finds your claim is frivolous.

If you (the responsible participant) have any questions about the Plan, you (the responsible participant) should contact the Plan Administrator. If you (the responsible participant) have any questions about this statement or about your rights under ERISA, or if you (the responsible participant) need assistance in obtaining documents from the Plan Administrator, you (the responsible participant) 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 (the responsible participant) may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

Qualified Medical Child Support Orders

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

Use-It-Or-Lose-It Rule

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

You (the responsible participant) may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you (the responsible participant) may

expect to receive, contingently or otherwise, under the Plan, except that you (the responsible participant) may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

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 and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you (the responsible participant) under federal tax law. However, the Company 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 (the responsible participant) should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you (the responsible participant) with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor is Savannah-Chatham County Public School System.

   Its address is 208 Bull Street, Savannah, GA 31401.

   Its telephone number is 912-395-5899.

   Its Employer Identification Number is 58-6000206.

   The Plan Administrator is Continuon Services, LLC, 1350 Spring Street, Suite 475, Atlanta, GA 30309.

   Its address and telephone number is that of the Plan Sponsor listed above.

2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number 501.

3. The Plan's designated agent for service of legal process is the chief officer of the entity named in paragraph 1. Any legal papers should be delivered to him or her at the address listed in paragraph 1. However, service may also be made upon the Plan Administrator.

4. The Company's fiscal year ends on December 31 and the plan year ends on January 1.