

**JPS Industries, Inc.**

**SUMMARY PLAN DESCRIPTION**

**For The**

**Flexible Benefits Program  
Dependent Care Spending Account Program  
Health Care Spending Account Program**

**Amended and Restated  
Effective January 1, 2004**

# The Flexible Benefits Program

Expenses for insurance, health care, or day care costs may consume a significant portion of your yearly budget. JPS Industries, Inc. ("JPS") has adopted several benefit plans which, taken together, are designed to help provide you and your family with financial assistance in meeting these expenses.

JPS sponsors three related benefit plans for its employees:

**JPS INDUSTRIES, INC. FLEXIBLE BENEFITS PROGRAM**  
**JPS INDUSTRIES, INC. DEPENDENT CARE SPENDING ACCOUNT PROGRAM**  
**JPS INDUSTRIES, INC. HEALTH CARE SPENDING ACCOUNT PLAN**

This booklet describes the terms and benefits of these plans as of January 1, 2004. The JPS Industries, Inc. Flexible Benefits Program acts as an "umbrella" over several pretax benefit options, such as coverage under one of the Corporation's Group Medical Plans or Other Group Insurance Plans. The JPS Industries, Inc. Dependent Care Spending Account Program and the JPS Industries, Inc. Health Care Spending Account Program, which are under the umbrella, offer you the option to use before-tax dollars to pay certain expenses which you would otherwise pay with after-tax dollars. This plan structure provides you with a substantial reduction in the cost of each benefit. For purposes of this summary plan description, the JPS Industries, Inc. Flexible Benefits Program and its underlying expense reimbursement plans will be collectively referred to as the "Flexible Benefits Program" or the "Plan," unless the context indicates reference to a specific plan.

Under the Plan, you will be able to choose benefits that best fit your needs and those of your family. You may purchase benefits or be reimbursed for benefit expenses with a portion of your income before federal income or social security taxes are withheld. The money you set aside is also exempt from most state income taxes and, in some cases, local income taxes. Because your taxable income is reduced, you pay less in taxes--and that can mean more money for you to spend or save.

JPS wants you to be able to take advantage of every available benefit under the Plan to the extent appropriate for your situation. To do this, you must understand the many options available to you. This summary plan description is intended to present a general and informative overview of the Plan. You should read it carefully so that you understand the provisions of the Plan and the benefits available to you. We want you to be fully informed before you enroll in the Plan and while you are a Participant. You should direct any questions you have to the Plan Administrator.

***There are Plan documents on file with the Plan Administrator which you may review if you desire. All matters of Plan administration are, in all respects, governed by the Plan documents. In the event there is a conflict between this summary plan description and the Plan documents, the Plan documents will control. JPS Industries, Inc. reserves the right to change or discontinue the Plan at any time.***

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# Flexible Benefits Program at a Glance

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## **Who Can Join**

The Plan is generally for individuals who: (a) are active full-time or part-time employees of JPS Industries, Inc. and affiliated employers that adopt the Plan ("your employer"); and (b) normally work (or are paid) for at least 30 hours a week.

## **Elections**

Before the beginning of each plan year, your employer will announce an election period. During the election period, you must complete an election form on which you may elect to set aside part of your pay to cover your estimated out-of-pocket costs for the benefits offered through the Flexible Benefits Program for the coming year. Your employer will set aside the amount you designate from your pay before federal and state income taxes and Social Security taxes are calculated.

## **Benefits You May Choose**

You may choose to receive your entire salary in cash, or to have your employer apply a portion of your before-tax pay to one or more of the flexible benefits:

- Health Care Expense Reimbursement
- Dependent Care Reimbursement
- Pretax payment of Group Medical Plan premiums.
- Pretax payment of premiums for Other Group Insurance Plans (currently life insurance).

## **Paying for Your Benefit Choices**

The amount you contribute will be withheld from your before-tax pay and applied toward the benefits you choose. Premiums for the Group Medical Plan and Other Group Insurance Plans will be paid directly by the Plan Administrator. Amounts you designate for reimbursement of qualified expenses will be accounted for in separate reimbursement accounts. You may file claims for reimbursement after incurring qualified expenses.

Since payroll deductions are made on a before-tax basis, taxes are less and take home pay will increase for most participants. Let's look at an example of how this works:

| <b>How Your Flexible Benefits Program Works</b>  |   |                       |
|--|---|-----------------------|
| Employee's Annual Income: \$30,000               |   |                       |
|  | <u>Before<br/>Plan</u>  | <u>After<br/>Plan</u> |
| Bimonthly income                                 | \$1,250   | \$1,250               |
| Minus qualified expenses*                        | <u>0</u>  | <u>195</u>            |
| Taxable income                                   | \$1,250   | \$1,055               |
| Minus withholding taxes**                        | <u>-293</u>   | <u>-249</u>           |
| Net take-home pay                                | \$ 957  | \$ 806                |
| Plus tax-free reimbursements                     | <u>0</u>  | <u>195</u>            |
| Net spendable income                             | \$ 957  | \$1,001               |
| <b>Tax savings</b>                               |   | <b>\$ 44</b>          |
| <hr/>  |   |                       |
| * Estimated bimonthly expenses:                  |   |                       |
| Dependent day care                               |   | \$ 100                |
| Health care expenses not covered by another plan |   | 35                    |
| Group Medical Plan premiums                      |   | <u>60</u>             |
| Total  |   | <b>\$ 195</b>         |
| **   | Withholding status assumed to be married with one allowance; Social Security federal, and state (South Carolina) withholding. |                       |

Because of these tax advantages, the Flexible Benefits Program is regulated by the Internal Revenue Service. Therefore, you must follow the Plan's rules for elections, reimbursement, and forfeitures.

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# Joining the Plan

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## **Who is eligible to join the Plan?**

The Flexible Benefits Program is generally available to individuals who: (a) are active full-time or part-time employees of JPS Industries, Inc. and affiliated employers that have adopted the Plan; and (b) normally work (or are paid) for at least 30 hours a week. However, certain individuals are not eligible to participate. They include individuals designated or otherwise classified by your employer as the following:

- Leased employees (as defined in the Internal Revenue Code);
- Independent contractors, notwithstanding any subsequent reclassification of such individual by any entity;
- Individuals paid by a third party that is unrelated to your employer; and
- Employees whose employment is governed by the terms of a collective bargaining agreement unless such agreement expressly provides for coverage by this Plan.

The above exclusions are based on the classification of the worker as designated by the employer, in its sole discretion, and will continue to apply notwithstanding subsequent reclassification by a court or government agency of competent jurisdiction.

You may choose to participate in the Group Medical Plan or Other Group Insurance Plan without participating in the Flexible Benefits Program. However, you must be eligible and choose to participate in the Flexible Benefits Program before you may elect to participate in either the Health Care Spending Account Program or the Dependent Care Spending Account Program.

## **When may I join the Plan?**

If you are an eligible employee (as described above), you may join the Flexible Benefits Program on the first day of the month following or coincident with the completion of 90 days of employment with the employer. Eligible employees may participate in the Health Care Spending Account Program after completion of one year of service with the employer. Coverage under a specific group medical plan or other group insurance plan may be delayed in accordance with the documents governing those plans.

If you do not join during your initial election period, you must wait until the next regular election period to join, unless you experience a “change in status event” or other qualifying event before the next regular election period or you qualify under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). See the section on the next page called “May I change my elections during the plan year?”

## **When are the election periods for our Plan?**

You are required by federal law to choose, during an “election period,” whether or not to participate in the Plan. Your *initial election period* will be the 30 day period prior to the date you meet the Plan’s eligibility requirements. You may re-enroll in the next regular election period. For each plan year, the *regular election period* will be December 1 to December 31 or such other period as determined by the Plan Administrator. If you experience a change in status event or other event that the Plan treats as allowing an election change, or you qualify for special enrollment under HIPAA, you will have a *special election period* beginning on the date of the change in status or other event, or HIPAA special enrollment event, and ending 30 days later.

## **What is the enrollment procedure?**

You must complete an enrollment form each year, even if you choose not to participate in the Plan. Return your enrollment form before the beginning of each plan year. *If you do not return an enrollment form, you will be deemed not to have made any election under the Health Care Spending Account Program and the Dependent Care Spending Account Program, but your previous year's elections under the group medical and other group insurance plan(s) will remain the same.* Your employer may use a combined enrollment form for the Flexible Benefits Program and the Group Medical Plan(s).

Note that if you decide to participate in the Dependent Care Spending Account Program, you will be required to provide the name, address, and taxpayer identification number or Social Security number of the dependent care provider. If you are unable to provide this information, participation in the Dependent Care Spending Account Program may be denied.

## **May I change my elections during the plan year?**

Federal regulations require that once you have enrolled, you cannot change your decision during the year except in the following circumstances:

- **Change in Status Event.** You may revoke your election of a qualified benefit (health care reimbursement, dependent care reimbursement, and pre-tax payment of insurance premiums) under the Plan and make a new election if you experience a “change in status event.” Currently, federal law considers you to have a “change in status event” if:
  - P You get married, divorced, legally separated, or you have your marriage annulled.
  - P Your spouse or child dies.
  - P You have a child, adopt a child, or have a child placed for adoption.
  - P Any of the following events that change your employment status or that of your spouse or your dependent: 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 the eligibility conditions of a cafeteria plan or other employee benefit plan of the employer of you, your spouse, or your dependent depend on the employment status of that individual and there is a change in that individual’s employment status with the consequence

that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment status.

P Your dependent satisfies or ceases to satisfy the requirements of an unmarried dependent.

P You, your spouse, or your dependent has a change in place of residence.

Other events may be designated as changes in status events by the Internal Revenue Service in its regulations. You should direct any questions about change in status events to the Plan Administrator. Any change in your election must be consistent with the change in status event and must be made within 30 days of the event.

■ Change in Cost or Coverage of Benefits other than Health Care Spending Account Benefits. You may change an existing election, or make a new election, for the remainder of the plan year with respect to your coverage under the pre-tax insurance premium benefit and dependent care spending account benefit (*but not the health care spending account benefit*) in the following circumstances:

P If the cost you are charged for a benefit significantly increases or significantly decreases during the plan year, you may make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for a benefit with a decrease in cost, or in the case of an increase in cost, revoking an election for that coverage and either receiving similar coverage on a prospective basis or dropping coverage if similar coverage is not available. In the case of benefits under the dependent care spending account program, the cost change must be made by a dependent care provider who is not your relative.

P If you, your spouse, or dependent have a significant curtailment of coverage under a plan during a period of coverage that is not a loss of coverage, you may revoke your election for that coverage and elect to receive similar coverage on a prospective basis. If you, your spouse, or dependent have a significant curtailment of coverage that is a loss of coverage, you may revoke your election and elect either to receive similar coverage on a prospective basis or drop coverage if no similar option is available.

P If a new benefit option or other coverage option is added to the Plan, or if coverage under an existing benefit or coverage option is significantly improved during the plan year, you (whether you previously made an election under the Plan) may revoke your election and elect coverage under the new or improved benefit option on a prospective basis.

P You may make a prospective election change that corresponds with a change made under another employer plan if the other plan permits participants to make mid-year election changes or participants may elect a period of coverage under the other plan that is different from the period of coverage under the Plan.

P You may make a prospective election to add coverage for yourself, your spouse, or dependent if you, your spouse, or dependent lose coverage under any governmental or educational group medical plan.

You must change your election within 30 days of receipt of written notice from the Plan Administrator of the significant change in cost, curtailment, or coverage of the benefit originally elected or the addition or improvement of a benefit option, or within thirty (30) days of written notice by a plan administrator of a change in coverage under another employer plan or loss of coverage under a governmental or educational group medical plan.

- Judgment, Decree or Order. If you receive a judgment, decree or order resulting from a divorce, legal separation, or change in legal custody, including a Qualified Medical Child Support Order (“QMCSO”), that requires accident or health coverage for your dependent(s), you may be allowed to change your election to comply with the order. You may terminate coverage for a child only if the order requires your spouse, former spouse or other individual to provide coverage for the child and that coverage is, in fact, provided. You must make a new benefit election within 30 days of receipt of the judgment, order or decree. Plan participants and beneficiaries can obtain, without charge, a copy of the QMCSO procedures from the group medical plan administrator(s).
- Family and Medical Leave Act. If you take leave under the Family and Medical Leave Act (“FMLA”), you may be allowed to change your election of group medical plan coverage as provided under the FMLA.
- Entitlement to Medicaid or Medicare. If you, your spouse, or your dependent become entitled 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 (the program for distribution of pediatric vaccines), you may be allowed to cancel or reduce coverage of such person under a group medical plan. Also, if you, your spouse, or dependent loses eligibility for such coverage, you may be allowed to commence or increase coverage of such person under a group medical plan.
- Special Enrollment Periods under HIPAA.
  - P If you, your spouse, or your dependent are covered under another group medical plan or have other health insurance coverage at the time coverage under your employer's group medical plan is offered, you decline coverage under your employer's group medical plan, and you state in writing at that time that you declined coverage under your employer's group medical plan because of the other coverage, and you, your spouse, or your dependent subsequently lose such coverage, you may be allowed to change your election as provided under HIPAA provided you give notice within 30 days after the date the other coverage expires.
  - P If a person becomes a dependent of a participant (or an employee who is eligible to become a participant) through marriage, birth, adoption, or placement for adoption, the spouse or dependent (or you if you are not already covered under your employer's Group Medical Plan), you may change your election as provided under HIPAA within 30 days of the marriage, birth, adoption, or placement for adoption. Such enrollment will be effective as of the dependent's birth, date of adoption (or placement for adoption), as applicable; and in the case of marriage, the enrollment will be effective the first day of the first month beginning after the date the completed request for enrollment is received.

## **When will my participation in the Plan end?**

While it intends to maintain the Plan indefinitely, JPS Industries, Inc. may amend the Plan, discontinue any or all benefits under the Plan, or terminate the Plan at any time for any reason.

Generally, your participation in the Flexible Benefits Program, Dependent Care Spending Account Program and Health Care Spending Account Program will end on the earlier of:

- When you leave your employment with JPS or other participating employer.
- When you are no longer eligible to participate in the Plan.
- When the Plan is terminated.
- When your election expires or is revoked by you.

In the event your participation ends, your coverage under the various benefits provided by the Plan will be governed by the provisions of the specific plans in which you are a participant. The documents given to you explaining those benefits describe their termination provisions. You may be allowed to continue your Group Medical Plan coverage under federal law (COBRA). You may also have the option of continuing your coverage under the Health Care Spending Account Program, provided you keep contributing to it. However, your contributions would be made with after-tax dollars. See “COBRA Continuation Coverage” below.

## **What happens if my employment ends during a plan year?**

Subject to applicable COBRA continuation requirements, if you terminate employment, you will be ineligible to participate for the remainder of the plan year. Your election will terminate on your last day of employment. If you are rehired, you may rejoin the plan when you again satisfy the eligibility requirements. However, if you are rehired within the same plan year, you generally may not make a new election until the next regular election period.

You may submit claims for qualified expenses incurred during the year of termination and prior to your termination date to the extent of the balance of amounts withheld prior to your date of termination, less the amount of any benefits previously paid from your reimbursement account(s) during the plan year. Claims must be submitted before March 31 of the next year. Any amounts remaining in your account(s) after this date will be forfeited.

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# Contributions

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## **How are Group Medical Plan and Other Group Insurance Plan contributions made?**

During each regular election period, you may elect benefit coverages for yourself and your dependents under the Group Medical Plans and/or Other Group Insurance Plans. An amount equal to the insurance premiums or other costs for the benefit coverages you elect will be withheld from your salary and applied directly to such benefit costs. Should the cost of coverage under the Group Medical Plans and/or Other Group Insurance Plans change during the plan year, the Plan Administrator has the authority to change your salary reduction election to the amount required to pay the new cost.

## **How are health care spending account and dependent care spending account contributions made?**

During each election period, you decide how much of your salary to place in your health care spending and dependent care spending accounts for the next plan year. The money you designate for reimbursement of dependent care or health care expenses will be subtracted from your pay (before taxes are calculated) and set aside in a reimbursement account(s). As you incur qualified dependent care and health care expenses throughout the plan year, you pay them out of your own pocket. Then you may file claims and your employer will reimburse you with tax-free dollars from the appropriate reimbursement account.

Because you are lowering your taxable income, you save on income taxes and Social Security taxes. Your future Social Security benefits may be reduced at retirement because Social Security taxes are not withheld on your contributions to the Plan. For most people, however, the current tax savings offset any future lower Social Security benefits.

## **How much may I elect to contribute to the Plan?**

During each election period, you should consider what your qualified expenses are likely to be for the coming year. It may be helpful to review your health care and dependent care costs for recent years. Also consider any changes that may occur during the coming year that may affect your expenses. Follow these easy steps to calculate your Plan contribution:

- Step 1: Select a level of coverage under the designated group insurance benefits that best fits your family's needs.
- Step 2: Decide how much of your salary you want to set aside for other benefits. Remember, the amount you elect will be deducted from your pay in equal installments during the year.

The Flexible Benefits Program and federal law limit the amount you may set aside for each of the benefits offered under the Plan:

- Your *maximum* contribution per year for health care reimbursement is an amount set by the Plan Administrator before the beginning of each Plan Year.
- If you are not married, your *maximum* contribution per year for dependent care reimbursement may not exceed the lesser of:
  - P Your earned income for the plan year, or
  - P \$5,000.
- If you are married, your *maximum* contribution per year for dependent care reimbursement may not exceed the least of:
  - P Your earned income for the plan year,
  - P Your spouse's actual or deemed earned income for the plan year, or
  - P \$5,000, (\$2,500 if married and filing separate income tax returns).
- Your *maximum* contribution per year for payment of group insurance plan costs is the cost of coverage for you and your family in the plan(s) in which you have enrolled.

“Earned income” is more fully described in the Plan documents. If you have any questions about the maximum amount of your elections, you should contact the Plan Administrator.

It is important to plan carefully. If your qualified expenses during the plan year are less than the amount you allocate to your reimbursement accounts, the balance of your accounts will be forfeited. Once you enroll in the Plan, you are committed to those benefit elections for the entire plan year, unless you experience an event that enables you to change your election during the year (see Section called “May I change my elections during the plan year” on pages 4-7 above).

### **Do limitations apply to participants who are highly compensated?**

Under the Internal Revenue Code, “highly compensated participants” and “key employees” generally are participants who are officers, shareholders, or highly paid. You will be notified by the Plan Administrator each plan year if you are a highly compensated participant or a key employee. If you are within these categories, your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor highly compensated participants, key employees, or their families. Federal tax laws state that a plan will be considered to unfairly favor key employees if they as a group receive more than 25% of all of nontaxable benefits provided under our Plan.

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

### **Will my reimbursement accounts earn interest?**

No interest or other earnings will be credited to your reimbursement accounts. Except as provided by law, all amounts in reimbursement accounts will be the property of JPS until paid out pursuant to the terms of the Plan.

### **What if I don't spend the entire amount in my reimbursement accounts?**

Under Internal Revenue Service rules, money you put into your reimbursement accounts that is not used to cover qualified expenses incurred during the plan year cannot be returned to you. The deadline for submission of reimbursement requests for expenses incurred during a plan year is March 31 of the next year. Federal law requires that the balance of your contributions be forfeited after the deadline. *Because forfeiture is possible, you must carefully evaluate the amount you elect to contribute to the Plan.*

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# Qualified Expenses

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If you elect to participate in the Health Care Spending Account Program or the Dependent Care Spending Account Program, a separate reimbursement account for health care expenses or dependent care expenses will be established for you. Since Group Medical Plan costs and Other Group Insurance Plan costs are paid as costs or premiums become due, reimbursement accounts are not necessary for pretax payment of those costs. The annual amounts you have elected will be spread out evenly during the year and withheld each pay period.

## HEALTH CARE SPENDING ACCOUNT

The health care spending account is designed to help you pay for qualified health care expenses that are not covered under any other plan. These expenses might include the cost of medical, dental, vision, and hearing services and supplies.

You may elect to reduce your pay by any amount up to the maximum amount designated by the Plan Administrator for the Plan Year to pay for qualified health care expenses. You may be reimbursed for qualified health care expenses up to the amount you elected for the full plan year. Health care expenses reimbursed through the Flexible Benefits Program *cannot also be claimed as a deduction for income tax purposes.*

### What are the requirements for “qualified health care expenses”?

Qualified health care expenses must:

- Be incurred by you, your spouse, or your dependent;
- Be incurred during the plan year, while you are a participant;
- Be considered health care expenses by the Internal Revenue Service; and
- Not be eligible for payment through any health insurance or other plan.

The Plan Administrator, in its sole discretion, may determine whether an over-the-counter drug or product will be considered a qualified health care expense for purposes of reimbursement under the Plan. Generally, an over-the-counter drug or product will be considered a qualified health care expense if it is used to alleviate or treat an existing personal injury or sickness, and an over-the-counter drug or product that is “merely beneficial to general health” will not qualify for reimbursement. However, a “general health” over-the-counter drug or product may be a reimbursable expense if it has been recommended in writing by a physician to alleviate or treat an existing medical condition and you provide appropriate written documentation to the Plan Administrator. In order for an over-the-counter drug or product to be reimbursed, you must provide the Plan Administrator with a receipt from the provider that includes the name of the drug or product, the amount of the purchase, and the date of purchase. If the above-required documentation is not provided, the over-the-counter drug or product will not be reimbursed under the Plan.

Premiums paid for other health plan coverages for you, your spouse, or your dependents are not qualified health care expenses.

## **DEPENDENT CARE SPENDING ACCOUNT**

The dependent care spending account is designed to help you pay for qualified dependent care expenses that make it possible for you and your spouse to work. It also may be used to help pay for the care of a disabled spouse or dependent.

You may elect to reduce your salary to pay for qualified dependent care expenses by any amount up to the maximum described on page 9. No reimbursement will exceed the balance of your dependent care reimbursement account at the time of the reimbursement. Dependent care expenses reimbursed through the Flexible Benefits Program *cannot also be claimed as a credit for income tax purposes.*

### **What are the requirements for “qualified dependent care expenses”?**

Under the Plan you will be reimbursed only for qualified dependent care expenses meeting all of the following conditions:

- The expenses are incurred during the plan year, while you are a participant;
- Each individual for whom you incur the expense is a dependent under age 13 whom you are entitled to claim as a dependent on your federal income tax return, or a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself;
- The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed;
- If the expenses are incurred for services outside your household, they are incurred for the care of a dependent under the age of 13, or who regularly spends at least 8 hours per day in your household;
- If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations;
- The expenses are not paid or payable to a child of yours under age 19 at the end of the year in which expenses are incurred; *and*
- The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

## **PRETAX PREMIUM PAYMENT**

The Flexible Benefits Program is designed to help you pay the cost of coverage for you and your family under a Group Medical Plan and or Other Group Insurance Plan sponsored by JPS. You may elect to reduce your pay by the cost of the coverages you choose. You may not make premium payments for other accident or health insurance plans through the Plan. Pretax payments made through the Flexible Benefits Program *cannot also be claimed as a credit or deduction for income tax purposes.*

### **What Group Medical Plan and Other Group Insurance Plan benefits are offered through the Flexible Benefits Program?**

The Flexible Benefits Program covers the Group Medical Plans sponsored by JPS. You and JPS share in the cost of the Group Medical Plans. In addition, the Flexible Benefits Program includes payment of the cost of coverage for you under Other Group Insurance Plans, which currently include life insurance. This life insurance is not sponsored by JPS. JPS allows a third-party insurance company to make this coverage available to employees and offer a way for you to enjoy tax advantages by paying for that coverage under the Plan. Through the Flexible Benefits Program, you may enjoy tax advantages while you help pay for your coverage. These lists of benefits available may change from time to time. The Plan Administrator will notify you in the event the lists change.

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# Request for Reimbursement

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A portion of the amounts you elect for qualified health care and dependent care expenses will be allocated to your reimbursement account(s) each pay period and reimbursed to you upon request. Claims for benefits provided under a Group Medical Plan or Other Group Insurance Plan should be submitted in accordance with the respective claims procedures found in each of the plans' policies. Please see the Plan Administrator if you have a question concerning the claims administration procedures for those plans.

## **How do I request reimbursement of health care or dependent care expenses?**

When you want to be reimbursed, you simply submit a claim form and the required attachments to the Plan Administrator. Claim forms are available from your Plan Administrator. Reimbursement payments will be made as soon as administratively feasible.

### Health Care Expenses:

- To submit a claim for health care expenses, you must provide a statement from the medical provider (e.g., the doctor, hospital, or drug store) showing that the nature of the health care expense, the date incurred, the amount of the expense, and a statement that such expenses are not payable through insurance or another reimbursement plan.
- Claims for reimbursement of over-the-counter drugs or products must include a receipt from the provider that indicates the product name, the date of purchase, and the amount.
- In addition to the requirements above, a claim for reimbursement of the cost of over-the-counter drugs or products that might otherwise be considered “merely beneficial to general health” must include written documentation from the treating physician indicating that the over-the-counter drugs or products are needed to alleviate or treat an existing medical condition.
- The Plan Administrator, in its sole discretion, may deny any claim for an over-the-counter drug or product if such drug or product does not fall within a reasonable interpretation of Revenue Ruling 2003-102 and the Internal Revenue Service's general guidelines.

### Dependent care expenses:

- To submit a claim for dependent care expenses, you must provide a statement from the dependent care service provider showing for whom the expenses were incurred, the amount of the expense, and the date(s) the expenses were incurred.

Only expenses incurred while you are a participant and during the applicable plan year may be reimbursed. Reimbursement payments generally are made in a manner similar to your employer's payroll practice.

The Plan Administrator must respond to your request for reimbursement of dependent care expenses within 90 days following the date you submit your claim (within 180 days under special circumstances, in which case you will be informed of the circumstances requiring the extension in writing prior to the end of the initial 90-day period).

The Plan Administrator must respond to your request for reimbursement of health care expenses within a reasonable time, but not later than 30 days following the date you submit your claim (unless special circumstances necessitate an extension of handling time). If special circumstances require additional time for handling the claim, you will be notified in writing prior to the end of the initial 30 day period that an extension of no more than fifteen (15) days is required. The notice of extension will specify the special circumstances requiring the extension; the date by which the Plan expects to render a decision, and any additional information required to resolve the claim. You have 45 days to provide the specified additional information.

If your claim for benefits is denied, the Plan Administrator will provide you with a written or electronic notice setting forth:

- The specific reason or reasons for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and
- An explanation of the Plan's claim review procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") following a denial or review, and
- In the case of a claim for reimbursement of health care expenses under the Health Care Spending Account Program, if the denial is based on an internal rule, guideline, protocol or other similar criterion, a statement that such rule, guideline, protocol or criterion was relied upon in making the denial and that a copy of it will be provided free of charge to you upon request.

On or before January 31 of each year, your employer will furnish each participant who has received a dependent care expense reimbursement during the previous year a written statement showing the amount of such reimbursement(s). This information will be included on your Form W-2 tax statement.

### **What if my request for reimbursement is denied?**

If the Plan Administrator denies your request for reimbursement, you or your representative (authorized in writing by you) may submit a written request to the Plan Administrator for review of the claim within 60 days following receipt of a denial of a claim for dependent care expenses (or within 180 days following receipt of a denial of a claim for health care expenses under the Health Care Spending Account Program). During this review process, you may submit written comments and other information relating to your claim and you will have reasonable access to, and copies of, all documents and other information relevant to your claim free of charge. Any items you submit to the Plan Administrator will be considered without regard to whether the items were considered in the initial benefit determination.

A document, record, or other information is considered relevant to your claim if it:

- was relied upon in making the claim determination;
- was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and that Plan provisions have been applied consistently with respect to all claimants; or
- in the case of health care expenses, constitutes a statement of policy or guidance with respect to the Plan concerning the denied claim.

If your claim for health care expenses under the Health Care Spending Account Program is denied, you may submit your written request for review within 180 days following receipt of notification of the denial. In addition, the review of a denied health care claim must be conducted by a Plan fiduciary different from the fiduciary who originally denied your claim and who is not a subordinate to the fiduciary who originally denied your claim. If the original denial of your claim was based on a medical judgment, the reviewing fiduciary must consult with an appropriate health care professional who was not consulted on the original claim and who is not subordinate to someone who was. The review must identify any medical or vocational experts consulted on the original claim. You may request, in writing, a list of those medical or vocational experts.

Within 60 days following your request for review of a denial of health care expenses (or within 120 days of your request for review of denied dependent care expenses under special circumstances, in which case you will receive written notice of the circumstances requiring the extension prior to the end of the initial 60-day period), the Plan Administrator will, after providing you with a full and fair review, render its final decision in writing or electronically to you.

The notice shall include:

- The specific reason or reasons for the denial;
- The specific Plan provisions on which the denial is based;
- A statement that, upon request and free of charge, you will be provided reasonable access to, and copies of, all information relevant to your claim; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA.

In the case of a decision on review of a claim for health care expenses under the Health Care Spending Account Program, the notice will also include the following:

- If the denial is based on an internal rule, guideline, protocol or other similar criterion, a statement that such rule, guideline, protocol or criterion was relied upon in making the denial and that a copy of it will be provided free of charge to you upon request; and
- The following statement: “You and the 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.”

**You must fully complete the claims review procedures described above before you (or any person claiming rights through you) may begin any legal or equitable action in connection with a claim for benefits under the Plan.**

**JPS and any persons acting in a fiduciary capacity at the direction of JPS shall have the maximum legal discretion to make decisions concerning the operation and administration of the Plan including, but not limited to, the provision or denial of benefits and factual determinations related thereto, and such decisions shall not be subject to further review unless determined to be an abuse of JPS’s discretion.**

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# COBRA Continuation Coverage

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## **What is "COBRA continuation coverage"?**

COBRA refers to a federal law that enables certain "Qualified Beneficiaries" to have the opportunity to continue coverage under the health care flexible spending account program upon the occurrence of a "Qualifying Event" that would otherwise result in such person losing coverage under that program. For purposes of this Summary Plan Description, "COBRA continuation coverage" means your right, or your spouse's and dependents' rights, to continue to be covered under the health care flexible spending account program offered under the Flexible Benefits Program.

## **Who are "Qualified Beneficiaries"?**

A "Qualified Beneficiary" is any person who, at the time of a Qualifying Event, is a participant or a spouse or dependent of a participant covered under the health care flexible spending account program offered under the Flexible Benefits Program. The term Qualified Beneficiary also includes children born to or placed for adoption with a participant during the period of COBRA continuation coverage. *An individual who fails to elect COBRA continuation coverage within the election period described below shall not be considered a Qualified Beneficiary.*

## **What is a "Qualifying Event"?**

Any of the following will be considered a "Qualifying Event" if it would otherwise cause the Qualified Beneficiary to lose coverage under the health care flexible spending account program:

- Death of a covered employee
- Termination (other than by reason of gross misconduct) of the covered employee or reduction of his or her hours of employment
- Divorce or legal separation of a covered employee
- A covered employee's becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act (Part A, Part B, or both)
- A change of a dependent child to nondependent status under a group health plan
- (In the case of a retired employee) the employer filing for Chapter 11 bankruptcy

## **Which Qualified Beneficiaries are eligible for COBRA continuation coverage?**

A Qualified Beneficiary may elect to continue to be covered under the health care flexible spending account program for the remainder of the plan year in which a Qualifying Event occurs *only if*, as of the date of the Qualifying Event, the maximum health care flexible spending account benefit available to the Qualified Beneficiary for the rest of the plan year exceeds the maximum amount that the health care flexible spending account program can require as payment for the COBRA continuation coverage for the remainder of the plan year. COBRA continuation coverage is not available to a Qualified Beneficiary who does not meet the preceding requirement.

## **What notices are required for COBRA continuation coverage?**

The following notices are required upon occurrence of a Qualifying Event if COBRA continuation coverage is available to a Qualified Beneficiary:

- In the case of termination or reduction of hours, death, entitlement to Medicare, or Chapter 11 bankruptcy, the Plan Administrator shall furnish each Qualified Beneficiary with written notification of the termination of regular coverage and his or her right to elect continuation coverage.
- In the case of divorce or legal separation, or a dependent child ceasing to be a dependent child under the group health plan (as more specifically described above), a Qualified Beneficiary must notify the Plan Administrator within 60 days of the Qualifying Event.

## **How do I elect COBRA continuation coverage?**

When a Qualifying Event occurs, any Qualified Beneficiary entitled to COBRA continuation coverage shall have a period to elect continuation coverage which begins on the date the coverage terminates, is of at least 60 days duration, and which ends not earlier than 60 days after the later of (i) the date coverage terminates, or (ii) the date a required notice is given of continuation coverage rights.

## **How long can an eligible Qualified Beneficiary continue COBRA coverage?**

- Lapse of Continuation Coverage Period. COBRA continuation coverage for an eligible Qualified Beneficiary will terminate as of the last day of the plan year during which the Qualifying Event occurred. Further continuation coverage under the health care flexible spending account program is not available.
- Automatic Termination of Continuation Coverage. COBRA continuation coverage will automatically cease if (1) JPS no longer offers group health coverage to any of its employees, (2) the required premium for continuation coverage is not paid within 30 days of the date due, (3) after COBRA continuation coverage is elected, a Qualified Beneficiary becomes covered under another group health plan that does not exclude or limit coverage for a preexisting condition of such individual, or (4) after COBRA continuation coverage is elected, a Qualified Beneficiary becomes entitled to receive benefits under Medicare.

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# Your Rights Under ERISA

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

## **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, 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 all documents governing the operation of the Plan, including insurance contracts, 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 the summary annual report.

## **Continue Group Medical Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under a group medical 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group medical plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group medical plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## **Prudent Actions by Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a 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 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 request 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 after you have exhausted all administrative remedies. 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 it should happen that Plan fiduciaries misuse the Plan's money, or 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 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 area 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.

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# Summary

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

If you have any questions about your plan, please contact the Plan Administrator.

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# Plan Summary List

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| <b>PLAN NAME</b>  | JPS Industries, Inc. Flexible Benefits Program, including JPS Industries, Inc. Health Care Spending Account Program and JPS Industries, Inc. Dependent Care Spending Account Program   |
| <b>EMPLOYER NAME AND ADDRESS</b>  | JPS Industries, Inc.<br>Park Central One, Suite 202<br>555 North Pleasantburg Drive<br>Greenville, South Carolina 29607<br>(864) 239-3900<br><br>A complete list of employers who have adopted the plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries as required by Department of Labor regulations. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if the employer is a plan sponsor, the sponsor's address. |
| <b>EMPLOYER ID NUMBER</b>   | 57-0868166   |
| <b>TYPE OF PLAN</b>   | Flexible compensation plan with options for health care expense reimbursement and dependent care expense reimbursement accounts and pretax payment of premium expenses   |
| <b>PLAN NUMBER</b>  | 501  |
| <b>PLAN FISCAL YEAR</b>   | January 1 through December 31  |
| <b>PLAN EFFECTIVE DATE</b>  | JPS Industries, Inc. Flexible Benefits Program was originally established May 9, 1988; amended and restated January 1, 1994, August 8, 1994, January 1, 2001 and January 1, 2004.  |
| <b>PLAN ADMINISTRATOR, AGENT FOR LEGAL SERVICE, AND NAMED FIDUCIARY</b> | JPS Industries, Inc.<br>Park Central One, Suite 202<br>555 North Pleasantburg Drive<br>Greenville, South Carolina 29607<br>(864) 239-3900  |
| <b>PLAN TRUSTEE</b>   | None   |
| <b>PLAN ADMINISTRATION</b>  | The Plan is administered by JPS Industries, Inc. through an administrative services agreement with:<br><br>Blue Cross Blue Shield of South Carolina<br>Post Office Box 100237<br>Columbia, South Carolina 29202<br>(800) 300-5248  |