Summary Plan Description

of the

ROCKFORD PUBLIC SCHOOLS
FLEXIBLE BENEFITS PLAN

January 2017

INTRODUCTION

Rockford Public Schools (the "District") maintains the **Rockford Public Schools Flexible Benefits Plan** ("Plan") for the benefit of its employees. The Plan allows you to design your own benefits package to suit your individual needs.

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the Plan. The Summary Plan Description is based upon the Plan provisions in effect as of January 1, 2017.

You should carefully read this Summary Plan Description and keep it for future reference. This Summary Plan Description does not replace the provisions of the Plan document. The Plan document governs the operation of the Plan. Every effort has been made to make this Summary Plan Description as complete and accurate as possible, without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan document, the terms of the Plan document will control.

If you have any questions about the Plan, please contact the Payroll/Employee Benefits Department.

ROCKFORD PUBLIC SCHOOLS

January 2017

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WHAT IS THE FLEXIBLE BENEFITS PLAN?

The Flexible Benefits Plan is a plan which allows you to design a benefits package to suit the individual needs of you and your family. You have the following benefit choices under the Plan:

- You may elect to pay your portion of the premium, if applicable, for health coverage under the District's group health plan on a pre-tax basis.
- You may waive the District-provided health coverage and receive additional compensation from the District.
- You may elect to reduce your pay to be reimbursed on a pre-tax basis for certain qualifying dependent care expenses.
- If you are only covered by the District's high deductible health plan, you may elect to reduce your pay to make contributions on a pre-tax basis to your health savings account ("HSA") in addition to any HSA contribution the District may make on your behalf.

More information regarding the types of tax-free benefits which you may choose, and the procedures for making your benefit elections are explained in the following sections of this Summary Plan Description.

References are made throughout this Summary Plan Description to the "plan year." Benefits under the Plan are elected on a plan year basis. The plan year is the 12-month accounting period for the Plan which is January 1 through December 31 for all benefits under the Plan except for the dependent care spending account. For purposes of making elections under the dependent care spending account portion of the Plan, the plan year is October 1 through September 30. Any references to "calendar year" also mean the 12-month consecutive period beginning January 1 and ending on December 31.

ELIGIBILITY AND PARTICIPATION

Eligibility and Beginning of Participation

You may become a participant in the Plan on the day you become eligible to participate in the District's group health plan if you are a member of a collective bargaining unit or employee benefits group that is eligible for participation in the Plan.

For the purpose of making pre-tax HSA contributions, you may become a participant in the Plan on the first day of any month on or after the date you become enrolled in the District's high deductible health plan and are eligible to make HSA contributions.

Termination of Participation

If you terminate employment with the District, or otherwise become ineligible to participate in the Plan, your participation in the Plan will terminate on the last day you are an eligible employee. For HSA purposes, this means the last day of the month in

which you are no longer an eligible employee. Your termination will have the following consequences:

- You will no longer be eligible to use pre-tax income to pay for coverage under the District's group health plan.

- You will no longer be eligible to receive additional compensation from the District for waiving the District-provided health coverage.

- You will no longer be eligible to set aside additional pre-tax income to pay for the reimbursement of certain dependent care expenses.

  If you have an amount remaining in your dependent care flexible spending account when you stop participating in the Plan, the amount in your account may continue to be applied toward the reimbursement of claims for eligible expenses incurred through the date your participation terminated.

- You will no longer be eligible to contribute to your HSA by reducing your pay (but you may still make tax deductible contributions directly to the HSA while you are a participant in the District's high deductible health plan (for example, pursuant to COBRA or a conversion privilege)).

In addition, the District may terminate your participation in the Plan for cause, which includes a termination for fraud or misrepresentation in an application for enrollment or a claim for benefits.

If you are rehired during the same plan year in which you terminate employment, there are special rules which may apply to you. If you become eligible to participate in the Plan again during the same plan year, you should contact the District's Payroll/Employee Benefits Department for the details regarding these special eligibility rules.

BENEFIT CHOICES

For each plan year, you may choose from the following benefits:

Health Insurance Benefits

The District maintains a group health plan which provides you and your dependents with health coverage. You may be required to pay a portion of the cost of the health coverage if you decide to participate. You have two choices with regard to the health coverage for you and your dependents:

- You may elect to receive the health coverage and pay your share of the cost, if applicable, with your pay reductions. The type and extent of your coverage under the District's group health plan is subject to the terms of the applicable collective bargaining agreement (for employees who are

members of a collective bargaining unit) or Board policy (for non-union employees).

- You may elect to waive the health coverage. In order for you to waive medical coverage, you must certify that you, your spouse and children (if any) will be enrolled in other minimum essential health coverage, such as through your spouse's employer's group health plan (other than an individual policy through the private market or the Exchange) for the entire period (i.e., plan year) for which coverage is being waived.

  If health insurance coverage is waived, the District will pay additional compensation to you during the plan year for which health coverage is waived. The amount of additional compensation is based upon the collective bargaining agreement or Board policy that applies to you. You will receive the additional Compensation in your paychecks during the plan year for which health insurance coverage was waived. The District will inform you of the time table for paying the additional compensation (for example, in equal installments over each pay period or quarterly, in a lump sum at year end, etc.). The additional compensation is subject to tax withholdings.

Dependent Care Spending Account

You may use your pay reductions to obtain reimbursement of qualifying medical expenses and/or dependent care expenses (see the "YOUR DEPENDENT CARE SPENDING ACCOUNT" section for details).

Health Savings Accounts

If you are only covered by the District's high deductible health plan (as that term is defined in the Internal Revenue Code) and not covered by other health insurance, you may use your pay reductions to contribute to an HSA. The District may also make HSA contributions on your behalf. The District will communicate the basis on which it will make any HSA contributions (for example, a flat dollar amount per participant, based on whether you are enrolled in single/employee-only or family coverage, etc.) (see the "YOUR HEALTH SAVINGS ACCOUNT" section).

YOUR PAY REDUCTIONS

You may select different types of tax-free benefits under the Plan by reducing your pay to purchase the benefits. For each plan year, you may elect to reduce your pay for each pay period in an equal amount. Your W-2 Form (which you use to compute your income taxes) will be reduced by the total amount of your pay reductions so you will not pay income taxes on this portion of your pay. In addition, your pay reductions are not subject to FICA.

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will need health

coverage under the District's group health plan, or will incur an expense which may be reimbursed through your dependent care spending account, or you are eligible to make HSA contributions, you could reduce your pay and obtain the coverage, pay the reimbursable expense or make the contributions with "before-tax" income rather than "after-tax" income.

The only disadvantage is that the pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits.

You may elect to reduce your pay as provided in the election process. The election procedures will be provided to you during the open enrollment period (see the "CHOOSING YOUR BENEFITS" section below).

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing benefits under the Plan. You may generally not change your election during the plan year, except as described below.

Initial Benefit Selection

Generally, you must make an election before the date that you become a participant in the Plan. The District will inform you of the election procedures. The election process may require the completion and return of a written election form and/or may require you to make your election electronically such as through an online computer system or telephone system. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make an election before the date that you become a participant in the Plan, you will not be eligible to pay your cost of coverage under the District's group health insurance plan on a pre-tax basis for the remainder of the plan year. You will not be eligible to receive any additional compensation for waiving health coverage. Your right to make pre-tax contributions to a dependent care spending account will also be waived for the remainder of the plan year. Instead, you will receive your regular pay for the remainder of the plan year through the District's payroll system. There are also special election rules regarding your HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section).

Annual Benefit Selection

For each type of benefit, there will be an open enrollment period before the start of each plan year. You may make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment period for that particular

benefit or if you have one of the events that permits change during a plan year (see the "CHANGING YOUR ELECTION DURING A PLAN YEAR" section).

If you do not make a new election during the open enrollment period, your prior election regarding the health insurance plan will be continued. You will be considered to have agreed to pay the appropriate premium for the subsequent plan year for this coverage. However, no pay reductions will be credited to your dependent care spending account unless you make a new election for each plan year. There are special election rules regarding your HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section).

CHANGING YOUR ELECTION DURING A PLAN YEAR

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain situations for which federal law permits a new election. These rules do not apply to an HSA (see the "YOUR HEALTH SAVINGS ACCOUNT" section). The next sections describe these situations.

Change In Status

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;
- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;
- An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age, or any similar circumstance; or
- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election under the Plan only if the election change is on account of, and corresponds with, the change in status that affects eligibility for coverage. However, the following special rules apply:

- If you want to decrease or cancel the District-provided health coverage because you become eligible for coverage under the plan of the employer of your spouse or dependent due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.

- With respect to your dependent care spending account, an election change may be made if your dependent attains age 13 or becomes or ceases to be totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not make a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

Changes to Coordinate with Health Care Reform

Under Health Care Reform, you may become eligible for District-provided group health coverage for a period of time and not lose eligibility even if you have a change in employment status where your hours of service will be reasonably expected to be reduced to an average of less than 30 hours of service per week. If this occurs, you can elect to cancel District-provided group health coverage even if the reduction in hours does not result in you ceasing to be eligible for the coverage. You may revoke coverage in this situation for yourself and any affected family members provided that you enroll in another plan that provides "minimum essential coverage" (as that term is defined under Health Care Reform) which is effective no later than the first day of the second month following the month that includes the date your District-provided group health coverage is revoked.

Similarly, if you are eligible to enroll in a "qualified health plan" (as that term is defined under Health Care Reform) through an Exchange during a special enrollment period or annual open enrollment period, you can elect to cancel District-provided group health coverage. This election is permitted provided that the revocation corresponds to the intended enrollment of you and your family members, if applicable, in a qualified health plan which is effective no later than the day immediately following the date your District-provided group health coverage is revoked.

FMLA Leaves and Other District-Approved Leaves of Absence

If you go on an FMLA leave, you may continue or revoke your elections regarding group health coverage even if you do not otherwise have a change in status. If you go on an FMLA leave, the following rules apply:

- Generally, the maximum FMLA leave period is 12 weeks per 12-month period (as that 12-month period is defined by the District). However, if you take an FMLA leave to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA leave is 26 weeks per 12-month period.

- You may continue or revoke your election of these benefits when you begin your FMLA leave.

- If you continue all or a portion of your election, you must continue making the necessary contributions for the benefits. You should contact the District's Payroll/Employee Benefits Department to discuss the procedures for making the contributions.

- If you terminated coverage during the FMLA leave, your coverage may be reinstated when you return to work. Reinstatement will occur immediately.

- You have the same election rights as an actively working participant during an open enrollment period and if a new or significantly improved benefit or coverage option is offered.

- If you take an unpaid FMLA leave and you receive additional compensation from the District for waiving health coverage, you will not receive this additional compensation for the time period when you are on the unpaid leave.

- If you do not return to work at the end of an FMLA leave, your participation in the Plan will terminate.

The rules described above will also apply if you go on a non-FMLA District-approved leave of absence. You should contact the Payroll/Employee Benefits Department for more information.

Special Enrollment Rights Under HIPAA

You may have special rights under HIPAA to enroll in the District's group health plan in these situations:

- You have lost other group health coverage. This could occur if your COBRA rights under the other plan were exhausted or you became ineligible for the other plan for a reason other than the nonpayment of premiums. You must make your new election within 30 days after the event occurs.

- You acquire a new dependent by marriage, birth or adoption. You must make your new election within 30 days after the event occurs.

- Your Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or you become eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under the District's group health plan. ("CHIP" is a state children's health insurance program.) You must make your new election within 60 days after the event occurs.

Court Order

You may change your election regarding the District's group health plan because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the District-provided health coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

Medicare or Medicaid Coverage

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage, (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce coverage for that individual under the District's group health plan. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase coverage for that individual under the District's group health plan.

Cost and Coverage Changes

If the cost of coverage under the District's group health plan changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

With respect to your dependent care spending account, if the cost of your dependent care provider changes during the plan year you may adjust your election. However, this opportunity is not available if the dependent care provider is your relative.

If coverage under the District's group health plan is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. Further, if the District offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change under this Plan.

YOUR PRE-TAX PREMIUM PAYMENTS

If you elect to receive coverage under the District's group health plan, your pay will be reduced by the amount stated in your election. Your premiums will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you must make arrangements with the District to pay your share of the premiums in order to continue coverage. .

YOUR HEALTH SAVINGS ACCOUNT ("HSA")

What is an HSA?

An HSA is a tax-favored IRA-type account established for an eligible individual (see the subsection below regarding who is eligible). Contributions to an HSA are fully vested when made and investment earnings are not taxable when earned. Distributions from the HSA are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years. This Plan provides a mechanism for you to make pre-tax contributions to an HSA.

Who is Eligible to Participate in an HSA?

You are eligible to make contributions to an HSA if you satisfy two requirements:

- You participate in the District's high deductible health plan ("HDHP") (as that term is defined in the Internal Revenue Code) with an annual minimum deductible of at least the amounts determined by law (which, for 2017, are $1,300 for single employee only coverage and $2,600 for family coverage); and

- You do not participate in any health plan that is not an HDHP. You will fail to satisfy this requirement if:

    - You participate in a "traditional" health plan (for example, through your spouse's employer); or

    - You participate in a medical spending account through your spouse's employer that permits reimbursement of <u>all</u> <u>types</u> of medical claims. If your spouse has a medical spending account through his/her employer, your spouse should check with his/her employer regarding how the medical spending account coordinates with your HDHP coverage.

How Can I Make HSA Contributions Through the Plan?

You may make pre-tax pay contributions (pay reductions) to your HSA through the Plan.

You may elect to make pre-tax contributions to your HSA as of your initial date of eligibility. If you do not make an election within a reasonable period of time before your initial date of eligibility, you may do so as of any later date based upon the procedures established by the plan administrator.

The normal initial and annual election procedures of the Plan do not apply to HSAs, nor do the restrictions on making mid-year election changes. Once you make an election, it will remain in force (including for subsequent plan years) unless you make a change. You can elect to increase, decrease, stop or begin pre-tax HSA contributions at least monthly, as of any prospective date, based upon procedures established by the plan administrator.

Who Administers My HSA?

An HSA must be held by a trustee or custodian (such as a bank). The District will inform you of the trustee or custodian it has selected for your HSA. If you elect to contribute to an HSA, the District will forward the contributions to the trustee or custodian. The money in the HSA will be invested by the trustee or custodian. The trustee or custodian will provide you with more information regarding how your HSA balance will be invested and any election opportunities you have with respect to the investments.

Is There a Limit on My Contributions?

The IRS limits the HSA contributions you may make each calendar year. The maximum amount depends on whether you are enrolled in single/employee-only or family coverage. For 2017, the maximum annual contribution to your HSA if you are enrolled in single/employee-only coverage under the HDHP will be $3,400. If you are enrolled in family coverage under the HDHP, your maximum annual HSA contribution for 2017 will be $6,750. (For purposes of the maximum, both your contributions and the District contributions (if applicable) on your behalf for the calendar year are considered.) The maximum may be adjusted each year for changes in the cost-of-living.

If you will be at least age 55 by December 31, your maximum annual HSA contribution limit for the calendar year will be increased under a special catch-up rule. For 2017, the additional catch-up contribution amount is $1,000, regardless of whether you are enrolled in single/employee-only or family coverage. This amount may be adjusted in future years for changes in the cost-of-living. So, for example, if you are enrolled in single/employee-only coverage under the HDHP for 2017 and will be at least age 55 by December 31, 2017, your maximum annual HSA contribution (employee and the District) limit for 2017 will be $4,400 ($3,400 + $1,000 = $4,400).

Will the District Make Contributions to My HSA?

In addition to your HSA contributions, the District may also make a contribution to your HSA. Any amount provided by the District will be based on a formula determined by the District which is permissible under the Internal Revenue Code and communicated to you during the open enrollment period.

How Can I Access My HSA Funds?

Once you establish an HSA, it may be accessed by following the procedures established by the trustee or custodian. You will be issued a debit card to use for this purpose. Alternatively, you will also typically be allowed to submit a written reimbursement request form to the trustee or custodian.

Amounts in your HSA can be distributed to cover your deductible requirements under the HDHP. You can also use your HSA money to pay for eligible health care expenses not covered by the HDHP. Amounts distributed for health care expenses are tax-free. You can also request a distribution for other purposes. For expenses other than eligible health care expenses, the amount distributed is taxable income and is also subject to a 20% penalty tax. But in certain circumstances the 20% penalty tax may be waived (such as for individuals who are disabled or at least age 65).

Amounts in your HSA can be distributed on a tax-free basis to cover your deductibles and other eligible health care expenses of you and your spouse. However, amounts can only be reimbursed on a tax-free basis to cover deductible and eligible health care expenses of your children and other dependents where they are your qualifying child or qualifying relative. In other words, if you have an older child (for example, age 25) who is covered under the HDHP as a result of the new definition of older dependent child required by health care reform, his or her out-of-pocket expenses will not be eligible to be reimbursed under the HSA on a tax-free basis unless the child is otherwise your tax dependent (i.e., qualifying child or qualifying relative).

What if I Change Jobs?

HSAs are permanent and portable. You can take your HSA with you to your next job. You can continue to grow the dollars in your account through investment or use the monies for eligible health care expenses. However, in order to actively contribute to an HSA, you must be covered under a qualified HDHP either through your new employer or an individual policy.

What Happens to My HSA after I Turn Age 65?

After you reach age 65, your HSA can be used to pay eligible health care expenses and certain insurance premiums like Medicare Parts B and D. Monies cannot be used to purchase a Medigap policy. Distributions for eligible health care expenses are tax-free. Distributions for other expenses are taxable.

The Plan only provides a way for contributions to be made to your HSA. As a result, the other rules concerning the HSA and the District's HDHP are not part of this Plan but will be provided to you in the communications materials regarding the HSA and HDHP benefits.

YOUR DEPENDENT CARE SPENDING ACCOUNT

If you have children or other dependents, you may have to pay others to provide care for them while you are at work. You may be reimbursed for these dependent care expenses under your dependent care spending account. Your dependent care spending account allows you to pay certain qualifying expenses using "before-tax" income rather than "after-tax" income. Your pay reductions are converted into the tax-free reimbursement of certain qualifying expenses.

The District will establish a separate bookkeeping account (referred to as a dependent care spending account) in your name for a plan year. The District will allocate your pay reductions to this account in the amount indicated in your election. When a claim for reimbursement is paid, the amount paid will be subtracted from your account.

Dependent Care Spending Account

What is the Difference Between My Dependent Care Spending Account and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "pre-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (up to $3,000 for one child and up to $6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

What Amount of Pay Reductions Should I Allocate to My Dependent Care Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care spending account and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the plan year, you should consider putting enough in your dependent care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you want to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (September 30), all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Dependent Care Spending Account?

Your dependent care expenses may be reimbursed under the Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by the District.

The Internal Revenue Code defines who is considered your dependent for this purpose:

- Your dependent includes a qualifying child who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her own financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes.

- Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

- Care for your dependent in your home (such as babysitting), if the dependent is either:

    - Your qualifying child under age 13; or

    - Your spouse or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.

- Care for your dependent outside of your home (such as in a day care center), if the dependent is either:

    - Your qualifying child under age 13; or

    - Your totally disabled (as defined above) spouse or qualifying relative who regularly spends at least eight hours per day in your home.

    This also includes pay, per an agreement with your daycare provider, which is required in order to hold a place for your

child(ren) during your short, temporary absence from work (for example, during vacation or your short term illness).

- Household services for the maintenance of your home (such as for a domestic maid or cook) as long as the services are performed in part for the benefit of your dependent.

May Amounts Paid to My Relatives Be Reimbursed?

You may hire whomever you want to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your dependents;
- Your spouse; or
- Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Are There Limits on How Much May Be Reimbursed?

Federal law limits the amount of dependent care expenses which may be reimbursed under the Plan. Generally, the limit is $5,000 per calendar year (or $2,500 if you are married and file a separate tax return).

However, if you earn less than $10,000 or your spouse earns less than $5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

- $250, if you have dependent care expenses for one dependent; or
- $500, if you have dependent care expenses for more than one dependent.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of dependent care expenses to the District's Payroll/Employee Benefits Department. You will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the dependent care expense was paid. You will also need to provide or certify that you have obtained the taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a

person) of the entity or person that provided the dependent care. You are required to obtain this information in order to report your dependent care expenses with your tax return on IRS Form 2441.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after the District receives the claim, but no less frequently than monthly. However, if your total unpaid claims are less than $25, the claims are held and paid when the total exceeds $25. The $25 minimum does not apply, however, at the end of the plan year and all claims will be paid to the extent of the balance in your dependent care spending account.

Claims for dependent care expenses incurred during a plan year may only be reimbursed out of your account for that plan year. Further, any amount remaining in your dependent care spending account at the time of your termination of participation may only be applied toward the reimbursement of claims for eligible dependent care expenses incurred through the date your participation terminated. All claims incurred during a plan year must be turned in no later than 90 days after the end of the plan year. If you do not timely submit a claim, the claim will be denied. Any amount then remaining in your account will be forfeited (see the "Forfeitures" subsection).

Other Rules Regarding Your Dependent Care Spending Account

Termination of Participation

If you terminate employment or otherwise become an ineligible participant under the Plan, you will be ineligible to have any additional pay reductions under the Plan credited to your dependent care spending account. **If you have an amount remaining in your dependent care spending account, you may continue to turn in claims for reimbursement of expenses incurred before you terminated employment.**

Forfeitures

Your pay reductions for each plan year may only be used to reimburse qualifying expenses incurred during that plan year. For purposes of the Plan, an expense is "incurred" when the service is rendered or the supply is provided.

Federal law requires the forfeiture of any amount remaining in your dependent care spending account after expenses incurred during the plan year are reimbursed. A forfeiture will occur if you fail to use the entire amount in your dependent care spending account. You should be careful not to overestimate your

expected expenses when you make your election. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have a forfeiture.

Appeal Procedure

If your claim under the dependent care spending account has only been partially reimbursed, or is denied, the plan administrator will give you written notice of the partial reimbursement or denial within 90 days after your claim is received, unless special circumstances require more time for processing the claim. If more processing time is required, the plan administrator will give you written notice of the extension before the initial 90-day period is completed. The extension will not be longer than 90 days from the end of the initial period.

You may make a written request to the plan administrator for a review of the decision. Your written request must be made within 90 days after the mailing date of your reimbursement check or notice of denial. You must refer to the Plan provisions on which your request is based and state the facts you believe justify a reversal or modification of the original decision. You must also include any information requested by the plan administrator.

You may examine pertinent documents and submit pertinent issues in writing. You may also have an authorized representative act for you. The plan administrator will review your claim within 60 days after receiving your written request.

The Plan will not be required to pay interest on any claim for benefits, regardless of when paid. Also, if a check for the payment of Plan benefits is not cashed within one year after the date it is issued, the check will be dishonored.

ADMINISTRATION

The District is the plan administrator. The plan administrator is charged with the administration of the Plan. The plan administrator has the authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The plan administrator will exercise its discretionary authority in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the plan administrator has the discretionary authority to interpret the terms of the Plan.

FUTURE OF THE PLAN

The District intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan at any time. However, your pay reductions which occur before the amendment or termination will continue to be used for your benefit.