

Sterling Community Unit School District #5 Flexible Benefits Plan
(With Premium Payment, Health FSA and DCAP Components)

SUMMARY PLAN DESCRIPTION

Plan Year January 1, 2011 through December 31, 2011

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Introduction

Sterling Community Unit School District #5 (the "Employer") sponsors the Sterling Community Unit School District #5 Flexible Benefits Plan (with Premium Payment, Health FSA and DCAP Components) (the "Flexible Benefits Plan") that allows eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. (Such plans are also known as "cafeteria plans.") Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This Summary describes the basic features of the Flexible Benefits Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Flexible Benefits Plan. If there is a conflict between the Flexible Benefits Plan documents and this Summary, then the Flexible Benefits Plan documents will control.

Q-1. How do employees pay for benefits on a pre-tax basis?

An Employee's election to pay for benefits on a pre-tax basis is made by entering into an Election Form/Salary Reduction Agreement (for Health FSA and Dependent Care FSA) with the Employer (ask the Human Resources Department for a copy if you have not received one); a Salary Reduction Agreement for Premium Payment benefits is provided on a separate form. Under that Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Q-2. What benefits may be elected under the Flexible Benefits Plan?

The Flexible Benefits Plan includes the following three benefits:

- *Premium Payment Component (currently including Health Insurance, Dental Insurance and Aflac Insurance Benefits)* - permits an Employee to pay for his or her share of contributions for the Health Insurance, Dental Insurance and Aflac Insurance Plans with pre-tax dollars. "Health Insurance Plan" means the major medical plan that your Employer maintains for Employees, their Spouses, and Dependents, providing major medical type benefits through a group insurance policy. Benefits provided under the Health Insurance Plan are called "Health Insurance Benefits," benefits provided under the Dental Insurance Plan are called "Dental Insurance Benefits" and benefits provided under the Aflac Insurance Plan are called "Aflac Insurance Benefits." Benefits provided generally under the Premium Payment Component (including any benefits that may be added at a later date) are called "Premium Payment Benefits."
- *Health Flexible Spending Arrangement (Health FSA)* - also called a medical expense reimbursement plan - permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-22) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called "Health FSA Benefits."
- *Dependent Care Assistance Program (DCAP)* - also called a dependent care flexible spending account - permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined in Q-33) with pre-tax dollars. Benefits provided under the DCAP are called "DCAP Benefits."

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Q-3. Who can participate in the Flexible Benefits Plan?

An Employee will be eligible to participate in the Flexible Benefits Plan (including the Health Insurance, Dental Insurance and Aflac Insurance Benefits, the Health FSA Benefits and the DCAP Benefits) as follows, provided that the election procedures in Q-5 are followed:

Certified Teachers: All regular full-time Certified Teachers, as defined in the Collective Bargaining Agreement, who work for the District a minimum of one-half (0.5) Full Time Equivalent (FTE) on a regular basis.

Support Staff: All regular full-time Support Staff who are budgeted and work for the District at least twenty (20) hours per week on a regular basis.

Administrative Staff: All regular full-time Administrative Staff who are budgeted and work for the District at least twenty (20) hours per week on a regular basis

Employees are eligible to enroll in the Plan:

Certified Teachers: Individuals hired after the end of one school year but before the beginning of the next subsequent school year, will be eligible on the first day of teacher attendance of the school year. Individuals hired during the school year will be eligible on the 1st day of their employment contract.

Support Staff: An individual will be eligible for coverage on the thirty-first (31st) Calendar Day following the date of hire or transfer to an eligible status.

Administrative Staff: An individual will be eligible for coverage on the first day of their employment contract with the District.

The effective date for elections made during the Annual Open Enrollment Period is January 1st.

Eligibility for the Health Insurance, Dental Insurance and Aflac Insurance Benefits is also subject to the additional eligibility requirements, if any, specified in the Health Insurance, Dental Insurance and Aflac Insurance Plans. An "Employee" is an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include the following:

- a. Any common-law employee who is a leased employee or any common-law employee classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee even if such an individual is later reclassified as a common-law employee;
- b. Any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency;
- c. Any employee covered under a collective bargaining agreement; or
- d. Self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Q-4. What tax savings are possible under the Flexible Benefits Plan?

(Note: A Pledge and Savings Worksheet is included in this SPD.) You may save federal and state income tax, and FICA (Social Security) taxes by participating in the Flexible Benefits Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Health Insurance, Dental Insurance and Aflac Insurance Benefits under the Flexible Benefits Plan. Suppose that you are married and have one child and that your share of the required contributions for Health Insurance, Dental Insurance and Aflac Insurance Benefits for family coverage is an annual total of \$3,400. Suppose also that your gross pay is \$40,000 and your Spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce \$3,400 to pay for the Health Insurance, Dental Insurance and Aflac Insurance contributions, then your annual take-home pay would be \$34,074. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only \$33,551. This is because by participating in the Flexible Benefits Plan for Health Insurance, Dental Insurance and Aflac Insurance contributions, you will be considered for tax purposes to have received \$36,600 in gross pay, so you save \$523 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers. **Caution:** The amount of the contributions used in this example is not meant to reflect your actual contributions—the actual contribution amounts will be described in a document provided separately to you by the Employer.

	<u>Using Cafeteria Plan*</u>	<u>Without Cafeteria Plan*</u>
1. Adjusted Gross Income	\$40,000	\$40,000
2. Salary Reductions for Premiums	(\$3,400)	\$0
3. W-2 Gross Wages	\$36,600	\$40,000
4. Standard Deduction	(\$11,400)	(\$11,400)
5. Exemptions	(\$10,950)	(\$10,950)
6. Taxable Income (line 3 minus lines 4 & 5)	\$14,250	\$17,650
7. W-2 Gross Wages	\$36,600	\$40,000
8. Federal Income Tax (line 6 @ tax schedule)	(\$1,428)	(\$1,849)
9. FICA Tax (7.65% of line 3)	(\$1,098)	(\$1,200)
10. After-Tax Premium Payments	\$0	(\$3,400)
1 Pay After Taxes and Premium Payments (line 7 1 minus lines 8, 9 & 10)	<u>\$34,074</u>	<u>\$33,551</u>

** The standard deduction, exemptions, and federal income tax rates for 2010 are estimated, using most current information available from the IRS.*

Q-5. When does participation begin and end in the Flexible Benefits Plan?

After you satisfy the eligibility requirements described in Q-3, you become a Participant by signing an individual Election Form/Salary Reduction Agreement. The Election Form/Salary Reduction Agreement will be available by the first day of the Open Enrollment Period. To participate in the Health FSA or Dependent Care FSA benefits, you must complete the Election Form/Salary Reduction Agreement and return it to the Human Resource Office within the time period specified in the enrollment materials. (If you have not received the enrollment materials and/or the Election Form/Salary Reduction Agreement, ask the Human Resources Department for copies.) An eligible Employee who fails to complete, sign, and file an Election Form/Salary Reduction Agreement as required will not be able to elect the Health FSA or Dependent Care FSA benefits under the Flexible Benefits Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs, as explained in Q-7).

Employees who actually participate in the Flexible Benefits Plan are called "Participants." An Employee continues to participate in the Flexible Benefits Plan until

- a. Termination of the Flexible Benefits Plan; or
- b. The date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

However, for purposes of pre-taxing COBRA coverage for Health Insurance, Dental Insurance and Aflac Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Flexible Benefits Plan for certain periods. See Q-12.

See Q-8 and Q-12 for information about how termination of participation affects your Benefits.

Q-6. What is the "Open Enrollment Period" and the "Plan Year"?

The Open Enrollment Period is the period during which you have an opportunity to participate in the Health FSA and Dependent Care FSA benefits under the Flexible Benefits Plan by signing and returning an individual Election Form/Salary Reduction Agreement (see Q-5). You will be notified of the timing and duration of the Open Enrollment Period, which will generally be from November 1st through November 30th for the next Plan Year.

The Plan Year is the 12 months beginning on each January 1st and ending on the next following December 31st.

Q-7. Can I change my elections under the Flexible Benefits Plan during the Plan Year?

You generally cannot change your election to participate in the Flexible Benefits Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various "Change in Election Events" that are described in the attachment entitled "When Can I Change Elections Under the Flexible Benefits Plan?" (available upon request from your Human Resources Department).

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Flexible Benefits Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Flexible Benefits Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Flexible Benefits Plan will cease and you will not be able to make any more contributions to the Flexible Benefits Plan for Health Insurance, Dental Insurance and Aflac Insurance Benefits, Health FSA Benefits, or DCAP Benefits. The Health Insurance, Dental Insurance and Aflac Insurance Benefits will terminate as of the date specified in the Health Insurance, Dental Insurance and Aflac Insurance Plans. See Q-12 and the booklets for the Health Insurance, Dental Insurance and Aflac Insurance Plans for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see Q-24. For reimbursement of expenses from the DCAP Account after termination of employment, see Q-35.

For purposes of pre-taxing COBRA coverage for Health Insurance and Dental Insurance Benefits and Health FSA Benefits, certain Employees may be able to continue eligibility in the Flexible Benefits Plan for certain periods. See Q-12.

If you are rehired within the same Plan Year and are eligible for the Flexible Benefits Plan, then you may make new elections, provided that you are rehired more than thirty (30) days after you terminated employment. If you are rehired within thirty (30) days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described in Q-3 before again becoming eligible to participate in the Plan.

Q-9. Will I pay any administrative costs under the Flexible Benefits Plan?

Yes. The fee is \$2.88 per month. This fee covers administration for the Health FSA and the Dependent Care FSA, whether you elect one or both benefits.

Q-10. How long will the Flexible Benefits Plan remain in effect?

Although the Employer expects to maintain the Flexible Benefits Plan indefinitely, it has the right to amend or terminate all or any part of the Flexible Benefits Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Flexible Benefits Plan be amended accordingly.

Q-11. What happens if my claim for benefits is denied?

Health Insurance, Dental Insurance and Aflac Insurance Benefits. The applicable insurance plan will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). For more information about how to file a claim and for details regarding the Health Insurance, Dental Insurance and Aflac Insurance Plans' claims procedures, consult the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for the Health Insurance, Dental Insurance and Aflac Insurance Plans.

Claims Under the Flexible Benefits Plan, Health FSA or DCAP. However, if (a) a claim for reimbursement under the Health FSA or DCAP Components of the Flexible Benefits Plan is wholly or partially denied, or (b) you are denied a benefit under the Flexible Benefits Plan (such as the ability to pay for Health Insurance, Dental Insurance and Aflac Insurance, Health FSA, or DCAP Benefits on a pre-tax basis) due to an issue germane to your coverage under the Flexible Benefits Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Flexible Benefits Plan document), then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Claims Processor. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Your appeal will be reviewed and decided by the Claims Processor or other entity designated by the Plan Administrator in a reasonable time not later than 60 days after the Claims Processor receives your request for review. The Claims Processor may, in its discretion, consult a medical expert. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA § 502(a) (where applicable).

Q-12. What is "Continuation Coverage" and how does it work?

USERRA. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

COBRA. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Sterling Community Unit School District #5 for more information. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Q-13. How will participating in the Flexible Benefits Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Flexible Benefits Plan participation will often more than offset any reduction in other benefits.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Health Insurance, Dental Insurance and Aflac Insurance Benefits, and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Health Insurance, Dental Insurance and Aflac Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Health Insurance, Dental Insurance and Aflac Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Health Insurance, Dental Insurance and Aflac Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health Insurance, Dental Insurance and Aflac Insurance Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see the attachment entitled "When Can I Change Elections Under the Flexible Benefits Plan During the Plan Year?" found at the end of this Summary).

Q-15. What are "Premium Payment Benefits"?

As described in Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Health Insurance, Dental Insurance and Aflac Insurance Benefits with pre-tax dollars by entering into a separate Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save federal and state income taxes, and FICA (Social Security) taxes. See Q-4.

The only Premium Payment Benefits offered under your Plan are for Health Insurance (this is major medical insurance), Dental Insurance and Aflac Insurance Benefits.

Q-16. How are my Premium Payment Benefits paid?

As described in Q-1 and in Q-15, if you select the Health Insurance, Dental Insurance and Aflac Insurance Plans described in Q-15, then you may be required to pay a portion of the contributions. When you sign the separate Salary Reduction Agreement for the Health Insurance, Dental Insurance and Aflac Insurance benefits, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Q-17. What are "Health FSA Benefits"?

As described in Q-2, a Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Health Insurance, Dental Insurance and Aflac Insurance Plans).

As described in Q-1, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save federal and state income taxes, and FICA (Social Security) taxes. See Q-4 for an example dealing with pre-tax payment of Health Insurance, Dental Insurance and Aflac Insurance contributions.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Q-18. What is my “Health FSA Account”?

If you elect Health FSA Benefits, then an account called a “Health FSA Account” will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-19. What are the maximum and minimum Health FSA Benefits that I may elect?

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to the minimum reimbursement amount of \$100 and the maximum reimbursement amount of \$5,000 per Plan Year. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

Q-20. How are my Health FSA Benefits paid for under the Flexible Benefits Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, suppose that you have elected to be reimbursed up to \$1,300 per year for Medical Care Expenses and that you have chosen no other benefits under the Flexible Benefits Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of \$1,300 during the Plan Year. If you are paid bi-weekly, then your Health FSA Account would reflect that you have paid \$50.00 (\$1,300 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected.

The Employer makes no contribution to your Health FSA Account.

Q-21. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). For example, a participant who has elected \$1,300 of coverage and contributed to his Health FSA Account during January and February (on a bi-weekly payroll schedule) - that means that by February 24 he would have contributed \$200.00 (\$50.00 times four pay periods). He hasn't made any prior claims for reimbursement during the calendar year, but on February 26 he incurs a Medical Care Expense in the amount of \$500. He submits that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the \$500 would be available to him for that expense, even though he has only contributed \$200.00 to his Health FSA Account at that point.

A physician's prescription must be submitted with claims for over-the-counter (OTC) drugs and medicines. However, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code § 213(d). (See Q-22.) Stockpiling is not permitted.

Q-22. What are “Medical Care Expenses” that may be reimbursed from the Health FSA?

“Medical Care Expense” means expenses incurred by you, your Spouse, or your Dependents for “medical care” as defined in Code § 213(d). Under the tax laws, “Medical Care Expenses” include expenses for OTC drugs and medicines as well as expenses for prescription drugs. However, a physician's prescription must be submitted with claims for over-the-counter (OTC) drugs and medicines and, as described above, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month.

The following list specifies certain expenses that are not reimbursable, even if they meet the definition of “medical care” under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of “medical care” under Code § 213(d) and other requirements for reimbursement under the Health FSA.

EXCLUSIONS:

- Health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Health Insurance, Dental Insurance and Aflac Insurance Plans);
- Long-term care services;
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- The salary expenses of a nurse to care for a healthy newborn at home;
- Funeral and burial expenses;
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
- Custodial care;
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement);
- Bottled water;
- Cosmetics, toiletries, toothpaste, etc.;
- Uniforms or special clothing, such as maternity clothing;
- Automobile insurance premiums;
- Transportation expenses of any sort, including transportation expenses to receive medical care;
- Marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- Any item that doesn't constitute “medical care” under Code § 213(d); and
- Any item that isn't reimbursable under applicable regulations.

Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

For purposes of the Health FSA, “Spouse” means the person who is legally married to you and is treated as a spouse under the Code. “Dependent” means your tax dependent under the Code, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a “qualifying relative” and certain other provisions of the Code's definition. See the Plan Administrator for more information about which individuals will qualify as your Dependents.

Note: Because of recent changes in the Code, some individuals' Medical Care Expenses may no longer qualify for tax-free reimbursement under a Health FSA. Your child (and in some cases, your stepchild, grandchild, brother, sister, stepbrother, stepsister, niece, or nephew) may no longer be considered to be your Dependent if he or she has the same principal place of abode with another person for more than half the year. For example, if you provide more than half of your child's support, but he or she lives with a grandparent all year, then your child could be the grandparent's tax dependent instead of yours (if other conditions are met). If you have children (or stepchildren, grandchildren, etc.) who do not reside with you and who are affected by this change, their expenses will no longer be eligible for tax-free reimbursement under the Health FSA. Other changes may apply as well to individuals who were previously eligible for tax-free Health FSA coverage.

Q-23. When must the Medical Care Expenses be incurred for the Health FSA?

For Medical Care Expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the same as the Plan Year for the Flexible Benefits Plan—it is the 12-month period beginning on January 1st and ending on the next following December 31st.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Flexible Benefits Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage, as described in Q-12).

Q-24. What must I do to be reimbursed for Medical Care Expenses from the Health FSA?

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the health insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form (a copy is included in this Summary Plan Description).

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control—see Q-11). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have until the March 31st after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See Q-11.)

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense (as defined in Q-23) and that it is not being paid for or reimbursed from any other source.

Q-25. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?

Yes. If the Medical Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the rest of that amount—this is called the “use-it-or-lose-it” rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Medical Care Expenses during the Plan Year, even if amounts are still left in your Health FSA Account. The difference between what you elected and what Medical Care Expenses were reimbursed will be forfeited at the end of the time limits described in Q-26.

Q-26. What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by the March 31st following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date—see Q-24). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any Health FSA Account benefit payments that are undaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Q-27. Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of “medical care” as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-28. What are “DCAP Benefits”?

As described in Q-2, a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse’s DCAP).

As described in Q-1, if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save federal and state income, taxes and FICA (Social Security) taxes. See Q-4 for an example dealing with pre-tax payment of Health Insurance, Dental Insurance and Aflac Insurance contributions.

Q-29. What is my “DCAP Account”?

If you elect DCAP Benefits, an account called a “DCAP Account” will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Q-30. What are the maximum and minimum DCAP Benefits that I may elect under the Flexible Benefits Plan?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the minimum reimbursement amount of \$100 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect \$3,000 in DCAP Benefits, you'll pay for the benefits with a \$3,000 salary reduction).

The amount of Dependent Care Expense reimbursement that you choose cannot exceed \$5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code § 129 when your election is made. The \$5,000 maximum will apply to you if:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or
- you are single or the head of the household for federal income tax purposes.

If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum DCAP Benefit that you may exclude from your income under Code § 129 is \$2,500 for a calendar year.

These maximums (\$5,000 or \$2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described in Q-33 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

Q-31 How are my DCAP Benefits paid for under the Flexible Benefits Plan?

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for \$2,600 per year for Dependent Care Expenses and that you have chosen no other benefits under the Flexible Benefits Plan. Your DCAP Account would be credited with a total of \$2,600 by the end of the Plan Year. If you are paid bi-weekly, then your DCAP Account would reflect that you have paid \$100 (\$2,600 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

The Employer makes no contribution to your DCAP Account.

Q-32. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. Using the example in Q-31, suppose that you incur \$1,500 of Dependent Care Expenses by the end of March 2011. At that time, your DCAP Account would only have been credited with \$700 (\$100 times seven pay periods), so only \$700 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining \$800 in Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account (you could request a \$100 reimbursement after each of the next eight pay periods).

Q-33. What are “Dependent Care Expenses” that may be reimbursed?

“Dependent Care Expenses” means employment-related expenses incurred on behalf of a person who meets the requirements to be a “Qualifying Individual,” as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
 - a person under age 13 who is your “qualifying child” under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
 - your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
 - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code or would qualify as your dependent except that: (1) he or she has income that equals or exceeds the exemption amount (for 2009, \$3,650 (before phase-out)); (2) he or she is married and files a joint return with his or her spouse; or (3) you (or your Spouse, if filing jointly) could be claimed as a tax dependent of another taxpayer.

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the non-custodial parent is entitled to claim the dependency exemption for the child. See the Plan Administrator for more information on which individuals will qualify as your Qualifying Individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.
- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.
- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your Spouse, a parent of your under age 13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.

For more information about what items are—and are not—deductible Dependent Care Expenses, consult IRS Publication 503 (“Child and Dependent Care Expenses”) under the heading “Tests to Claim the Credit.” But use the Publication with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code § 21 (“the Dependent Care Tax Credit,” discussed further below), not what is reimbursable under a DCAP. In fact, some of the statements in the Publication aren’t correct when determining whether that same expense is reimbursable under your DCAP. This is because there are several fundamental differences between what expenses qualify for the Dependent Care Tax Credit (under Code § 21) and what expenses are reimbursable under a DCAP (under Code § 129). Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a DCAP. (For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the DCAP, the expense must have been incurred during the Plan Year for which reimbursement is sought (see Q-34).)

Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year (after your salary reductions under the Flexible Benefits Plan);
- the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
- either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status, as described further in Q-30.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is \$5,000.

Q-34. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP is the same as for the Flexible Benefits Plan—it is the 12-month period beginning on January 1st and ending on December 31st.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Flexible Benefits Plan became effective, for any expenses arising before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except as described in Q-35).

Q-35. What must I do to be reimbursed for my Dependent Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCAP Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form (a copy is included in this Summary Plan Description).

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control—see Q-11). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until March 31st after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible; you can also be reimbursed for expenses incurred in the month following your termination of participation if such month is in the current Plan Year and your claim is submitted by the 90-day deadline. You will be notified in writing if any claim for benefits is denied. (See Q-11.)

To have your claims processed as soon as possible, please read Q-11. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in Q-34) and that it is not being paid for or reimbursed from any other source.

Q-36. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount in your DCAP Account— this is called the “use-it-or-lose-it” rule under applicable tax laws. (No grace period is provided under the DCAP.) In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the time periods described in Q-37.

Q-37. What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year by the March 31st following the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 90 days after the date you ceased to be eligible—see Q-35). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

Also, any DCAP Account benefit payments that are undaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

Q-38. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-30. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (“Child and Dependent Care Expenses”) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-39. If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see Q-40). For example, if you elect \$3,000 in coverage under the DCAP and are reimbursed \$3,000, but you had Dependent Care Expenses totaling \$5,000, then you could count the excess \$2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

Q-40. What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account \$3,000 of such expenses for one Qualifying Individual, or \$6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of \$1,050 for one Qualifying Individual, or \$2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses (producing a maximum credit of \$600 for one Qualifying Individual, or \$1,200 for two or more Qualifying Individuals). The maximum 35% rate is reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) by which your adjusted gross income exceeds \$15,000.

Example: Assume that you have one Qualifying Individual for whom you have incurred Dependent Care Expenses of \$3,600, and that your adjusted gross income is \$20,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first \$3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $\$3,000 \times 32\% = \960 . If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $\$3,600 \times 32\% = \$1,152$, because the entire expense would have been taken into account, not just the first \$3,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 (“Child and Dependent Care Expenses”). You may also wish to consult a tax advisor, as discussed below.

Q-41. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax free?

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person’s tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 (“Child and Dependent Care Expenses”) to help you.

Ask the Plan Administrator if you need further information about the DCAP or the Dependent Care Tax Credit, but remember that the Plan Administrator is not providing legal advice. Your Employer may also be able to provide you with a worksheet or tax calculator to help you make the comparison—ask the Human Resources Department if you would like to use one or both of these. But if you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-42. What is the Debit Card Program?

The Sterling Community Unit School District #5 Flexible Benefits Plan has implemented an electronic payment card (“Debit Card”) program that allows participants to pay for medical expenses from their Health FSA Account, or dependent care expenses from their DCAP FSA Account, at the time the expense is incurred. A Debit Card will be issued to each employee enrolled in the Health FSA or DCAP Components of the Flexible Benefits Plan. The Debit Card is the property of the Employer, and must be returned to the Employer when you cease to participate in the Flexible Benefits Plan.

Participants are not required to use the Debit Card. Instead, paper claims may be submitted to the Claims Processor for reimbursement by check. The choice to use the Debit Card or file a paper claim is up to the participant.

Q-43. Can I get an extra Debit Card for my spouse?

Additional Debit Cards may be obtained for an employee’s eligible dependents age 18 and older to use. Additional cards must be requested on the Election Form/Salary Reduction Agreement. The employee must provide the full name, date of birth and Social Security Number of the dependent who will be using the card. *Note:* there may be fee for additional cards.

Q-44. How does the Debit Card work?

You will receive a signature based MasterCard® Debit Card, delivered to you via first class mail (U.S. Postal Service) in a plain white standard sized #10 windowed envelope; your address displays through the window. Expect the Debit Card to arrive within ten (10) days after the beginning of the plan year. The Debit Card is limited to the amount you elect as your annual contribution.

The card is a signature based debit card. No Personal Identification Number (PIN) is included with the card. If you are presented with the option at the merchant terminal of choosing credit or debit, you should always select credit in order to sign for the purchase. Selecting debit will prompt you to enter a PIN which you will not have, and this will result in a denied transaction.

For medical expenses: You will be able to use the Debit Card at most merchants and service providers with a health care-related Merchant Category Code (MCC). Some of these providers currently use inventory information approval system (IIAS) codes which automatically verify that the purchase made with the card is for an eligible medical expense. You may also be able to use the card to pay for health care expenses that have IIAS codes, even if the provider does not have a health care-related MCC. Your card will be declined if you try to use it to purchase items or services without an appropriate IIAS code, or from a provider without a valid MCC.

For dependent care expenses: You will be able to use the Debit Card at service providers with a dependent care-related Merchant Category Code (MCC). Keep in mind that not all dependent care service providers will accept the Debit Card. Your card will be declined if you try to use it to pay for services from a provider without a valid MCC.

Q-45. What expenses can I use the Debit Card to pay for?

The Debit Card can be used to pay for:

- Eligible medical expenses incurred by you, your spouse, or your dependents for “medical care” as defined in IRS Code § 213(d) (see Q-22); (please note that over-the-counter (OTC) drugs and medicines may not be purchased with the Debit Card); and/or
- Eligible “dependent care” expenses, as defined in IRS Code § 129 (see Q-33), for employment-related expenses incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed.

By signing the Election Form/Salary Reduction Agreement to participate in the Health FSA and/or DCAP benefits of the Flexible Benefits Plan, you agree and certify that you will only use the card for your eligible medical care and/or dependent care expenses. You also agree that with each use of the Debit Card, you certify that any expense paid with the Debit Card has not been reimbursed and that you will not seek reimbursement from any other source. Each year when you re-enroll in the Flexible Benefits Plan at Open Enrollment, you will be required to reaffirm that you will use the card in accordance with the provisions of the Flexible Benefits Plan.

Q-46. How does the plan determine if I have used the Debit Card for an eligible expense?

All expenses paid with the Debit Card must be validated (sometimes referred to as “substantiation”). Some expenses may be validated at the time the expense is incurred, such as with a valid MCC or IIAS code. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. By signing the Election Form/Salary Reduction Agreement, you agreed to acquire and keep receipts for expenses paid with the card, and to submit any receipt to the Claims Processor upon request, that describes (1) the service or product, (2) the date of the service or sale, and (3) the amount paid.

You should keep all receipts for medical care and dependent care expenses as evidence in the event of an IRS audit (some call this the “shoebox rule”), even if the Claims Processor does not request the receipt for validation. The Employer suggests keeping the receipts for seven years.

Q-47. What happens if I use the Debit Card to pay for ineligible expenses?

In spite of the safeguards the Plan has in place to avoid payment of ineligible expense, occasionally this does happen. If the Debit Card is used to pay for ineligible expenses, you will be required to repay the Employer for such card payments. You will be denied access to the Debit card until the debt is repaid. If you fail to repay the ineligible amount, it will be deducted from future claims. Amounts still outstanding will be withheld from your wages by the Employer, to the extent consistent with applicable law. If all of these correction procedures fail, the employer will treat the unpaid amount as any other business debt and will take the same steps it would take to collect any other business debt which may include wage garnishment or even a lawsuit.

Q-48. What are my ERISA Rights?

The Flexible Benefits Plan is not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Health Insurance, Dental Insurance and Aflac Insurance Plans are governed by ERISA. Note: This Summary Plan Description does not describe the Health Insurance, Dental Insurance and Aflac Insurance Plans. Consult the Health Insurance, Dental Insurance and Aflac Insurance Plan documents and the separate Summary Plan Descriptions for the Health Insurance, Dental Insurance and Aflac Insurance Plans.

Your Rights. As a participant in the Flexible Benefits Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You have a right to continue your Health Insurance, Dental Insurance and Aflac Insurance Plan coverage (and, in some cases, your Health FSA coverage) for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health 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. (Note: This does not apply to the Health FSA, which is an "excepted benefit" under HIPAA.)

HIPAA Privacy Rights. Under another provision of HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

Fiduciary Obligations. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants.

No Discrimination. 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 plan benefit or exercising your rights under ERISA.

Right to Review. 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.

Enforcing Your Rights. Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the plan's claims procedures and, if applicable, filed a timely appeal of any denial of your claim).

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

Q-49. What other general information should I know?

This Q-49 contains certain general information that you may need to know about the Plan. Note: This Summary Plan Description does not describe the Health Insurance, Dental Insurance and Aflac Insurance Plans. Consult the Health Insurance, Dental Insurance and Aflac Insurance Plan documents and the separate Summary Plan Description for the Health Insurance, Dental Insurance and Aflac Insurance Plans.

General Plan Information

- Name: Sterling Community Unit School District #5 Flexible Benefits Plan.
- Plan Number: 15080.
- Effective Date: January 1, 2005.
- Plan Year: January 1st to December 31st. Your Plan's records are maintained on this 12-month period of time.
- Type of Plan: Welfare plan providing Health Insurance, Dental Insurance and Aflac Insurance Benefits, Health FSA Benefits, and DCAP Benefits.

Employer/Plan Sponsor Information

- Name and Address:
Sterling Community Unit School District #5
410 East LeFevre
Sterling, Illinois 61081
- Federal employee tax identification number (EIN): 36-2746264.

Plan Administrator Information

- Name, address, and business telephone number:
Sterling Community Unit School District #5
410 East LeFevre
Sterling, Illinois 61081
(815) 626-5050
- The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will answer any questions that you may have about our Plan. You may contact the Plan Administrator at the above address for any further information about the Plan.

Claims Processor

- Name, address, and business telephone number:
Butler Benefit Service, Inc.
P.O. Box 3310
Davenport, Iowa 52808-3310
(563) 327-2280
- The Plan Administrator appoints the Claims Processor to provide consulting services in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

Funding Medium and Type of Plan Administration.

- The Health FSA Component is a group health plan. The health FSA is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

Named Fiduciary

- The named fiduciary for the Health FSA Component is:
Sterling Community Unit School District #5
410 East LeFevre
Sterling, Illinois 61081
(815) 626-5050

Agent for Service of Legal Process

- The name and address of the Plan's agent for service of legal process is:
Sterling Community Unit School District #5
410 East LeFevre
Sterling, Illinois 61081

Qualified Medical Child Support Order

- The Health Insurance, Dental Insurance and Aflac Insurance Plans and the Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

- Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance, Dental Insurance and Aflac Insurance Plans Documents and Information

- This Summary Plan Description does not describe the Health Insurance, Dental Insurance and Aflac Insurance Plans. Consult the Health Insurance, Dental Insurance and Aflac Insurance Plan documents and the separate Summary Plan Descriptions for the Health Insurance, Dental Insurance and Aflac Insurance Plans.