Community High School District #155

FLEXIBLE SPENDING PLAN

Plan Document/Summary Plan Description

Amended and Restated January 1st, 2012

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Section 1: **Plan Purpose and Introduction**

The Community High School District #155 Flexible Benefits Plan (the "Plan") is a benefit program that allows eligible Employees to use pre-tax benefit dollars through payroll deduction to pay for insurance premium(s), unreimbursed medical expenses and dependent care expenses. Section 125 of the Internal Revenue Code permits Community High School District #155 to offer you the opportunity to participate in designing your own personalized benefit plan on a pre-tax basis.

Savings are achieved because this Plan enables Eligible Employees to pay for the above expenses with pre-tax dollars -- before federal and state income taxes and social security taxes are deducted.

This document and the benefits described within it, is intended to supersede all previously distributed materials. Although we hope and expect to continue the coverage described, we necessarily reserve the right to either modify or discontinue the benefits under the Plan at any time. The Employer will be notified in writing of any material changes to the Plan. If the Plan benefits are discontinued, benefits will be paid for eligible expenses incurred prior to the date of termination.

This Plan is intended to qualify as a "cafeteria plan" under Code §125, and regulations issued there under and shall be interpreted to accomplish that objective.

The Health FSA option is intended to qualify as a "self-insured medical reimbursement plan" under Code §105, and the health care expenses reimbursed there under are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The Dependent Care FSA option is intended to qualify as a "dependent care assistance plan" under Code §129, and the dependent care expenses reimbursed there under are intended to be eligible for exclusion from participating Employee's gross income under Code §129(a)

The Employer has appointed Group Administrators, Ltd (GAL) whose address is 915 National Parkway, Suite F, Schaumburg, IL 60173 and whose telephone number is 847-519-1880 as claims manager/administrator.

This Plan Document/Plan Summary describes the basic features of the Flexible Spending Benefits Plan, how it operates, and how to get the maximum advantage from it.

***Section 2*: Definitions**

"Account(s)" means the Health Flexible Spending Account and the Dependent Care Flexible Spending Account described in Section 6.

"Administrator" means Community High School District #155.

"Annual Enrollment Period" with respect to the Plan year means the period preceding a new plan year prescribed by the Administrator.

"Benefits" means the Premium Contribution Payment Benefit, the Health FSA Benefit and the Dependent Care FSA Benefit offered under the Plan.

"**Benefit Package Option**" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

"Change in Status" has the meaning described in Section 7.

"Claims Administrator" means Group Administrators, Ltd, or GAL as appointed by the Plan

Sponsor. **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as

amended. **"Code"** means the Internal Revenue Code of 1986, as amended.

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) Salary Reduction election under this Plan, (b) any salary reduction election under any other cafeteria plan, and (c) any compensation reduction under any Code § 132(f) (4) plan; but determined after (d) any salary deferral elections under any Code 401(k), 403(b), 408(k) or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the prior sentence.

"Dependent Care FSA" means the "dependent care assistance program" as described in Section 6.

"Dependent or Qualifying Dependent" means any individual who is a qualifying child or qualifying relative, or other qualifying tax dependent of the Participant as defined in Code § 152 (as modified by Code § 105(b), the Affordable Care Act of 2010 and other applicable law, including provisions to extend dependent status to age 27).

In the case of an individual who is permanently and totally disabled (as defined in Code § 22(e) (3)) at any time during such calendar year, the age requirement for a qualifying child does not apply. No person shall be considered a dependent of more than one Employee. If Employer employs both an Employee and an Employee's spouse, dependent children may be covered by either spouse, but not by both.

As applicable under current law, the requirement that a Dependent child have full-time student status in order to extend coverage past a stated age will generally not apply if the child's failure to maintain full-time status is due to a medically necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is medically necessary, coverage may continue for up to a year after the date the medically necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the medically necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student.

Except for a student who is on a medically necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law as applicable.

Notwithstanding the foregoing, the Health FSA option will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Effective Date" means the date of this Plan January 1st, 2003.

"Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended and means protected health information that is transmitted or maintained in any electronic media.

"Eligible Employee or Employee" means an employee who satisfies the eligibility conditions for the Employer's Group Insurance Benefit Plan and/or this Flexible Spending Plan, but generally excludes any person who is employed as an independent contractor or any person who is considered self-employed under Code § 401(c), as well as a greater than two percent (2%) shareholder in a

Subchapter S corporation, as defined under Code § 1372(b), a partner in a partnership or an owner or member of a limited liability company that elects partnership status on its tax return.

"Employer" means **Community High School District #155** (and any other related employer, or other organization that succeeds to its business and elects to adopt or continue this plan).

"Enrollment Period" means one calendar month preceding the Plan year, or such other period as prescribed by the Administrator.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"FSA Benefits" has the meaning described in Section 6.

"Group Insurance Benefit Plan" means the insurance plan(s) that the Employer maintains for its Employees (and for their Dependents and/or spouse) that may be eligible under the terms of such plan), providing major medical, dental and vision care type benefits as amended.

"Health FSA" means a Health FSA arrangement.

"Health FSA Account" means the account described in Section 6.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Section 3. Participants include (a) those who elect one or more of the benefit options described in Section 4 and (b) those who elect instead to receive their full salary in cash and to pay for their share of their contributions under the Group Insurance Benefits Plan (if any) with after-tax dollars outside of this Plan and who have not elected any Health FSA Benefits or Dependent Care FSA Benefits.

"Period of Coverage" means the plan year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the plan year following the date participation commences, as described in Section 3; and (b) for Employees who terminate participation, it shall mean the portion of the plan year prior to the date participation terminates, as described in Section 3.

"Plan" means the Premium Payment Benefits, Health FSA Benefits and Dependent Care FSA Benefits as described in this Plan Document/Plan Summary Document.

"Plan Administrator or Plan Sponsor" means Community High School District #155.

"Plan Document/Plan Summary Description" means the Plan's governing documents and instruments (the documents under which the Plan was established and is maintained), including the Community High School District #155 Flexible Spending Plan Summary Plan/Plan Document, as well as, any other plan document created in the future that supplements the Employer's Flexible Spending Plan Document.

"Plan Year" means the 12-month period beginning January 1 and ending December 31.

"Premium Payment Benefit" means the amount set aside for the Group Insurance Benefit Plan(s) under Section 5 that are paid for on a pre-tax salary deduction basis.

"QMCSO" means a qualified medical child support order, as defined in ERISA §609(a).

"Salary Reduction" means the amount by which the Participant's compensation is reduced and applied by the Employer under this Plan to pay for one or more of the benefits, as permitted for the applicable option, before any applicable state and/or federal taxes have been deducted from the Participant's compensation (i.e. on a pre-tax basis).

"Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as spouse under the Code). Notwithstanding the above, for the purpose of the Dependent Care FSA, the term, "spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means an individual who, during each of five or more calendar months during the plan year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

"Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

All other defined terms in this Plan shall have the meanings specified in the various Sections of the Plan in which they appear.

Section 3: Eligibility and Participation

You are eligible to enroll in this Plan if you meet all eligibility requirements set forth in this Section 125 Flexible Spending Plan and if you are a permanent Employee of Crystal Lake Community High School District #155, and satisfy all eligibility requirements for the Group Health Insurance Plan.

If a Participant has satisfied these requirements, he or she may elect to participate in any of the benefits available under the Plan during the Annual Enrollment Period designated by the Employer, if he or she is newly eligible, or if he or she has a qualifying status change as described in Section 5.

3.1 How To Enroll

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made during the month preceding the Plan year for which it will be in effect – during the "Enrollment Period." Each year Community High School District #155 will provide you with written information that will enable you to identify the benefits in which you wish to participate and the portion of your Salary Reduction that may be applied to provide each benefit.

If for some reason as a newly eligible Employee, you fail to complete an election form, then you will be deemed to have elected not to participate in this benefit. If you are already a plan participant and you fail to complete an election form for the upcoming plan year, you are eligible to maintain the Premium Payment Benefit, if any, that you elected for the prior year, but will not be eligible to participate in either the Health FSA or the Dependent Care FSA benefit.

You may design a completely new plan each year, keeping in mind that your choices are in effect for the entire plan year. Only under special circumstances, such as change in status, may you apply to

change your selected benefits. Generally, the change must be consistent with the event; to the extent it is necessary or appropriate as a result of the change. If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pre-tax payment of premiums until the next plan year.

3.2 Termination of Participation

Your participation in this Plan will cease upon the earlier of:

- The expiration of the Period of Coverage for which you have elected to participate (unless during the annual Enrollment Period for the next plan year you elect to continue participating);
- The termination of this Plan;
- The date on which you cease (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee;
- The date you revoke your election to participate under a circumstance when such change is permitted under the terms of this Plan.

Termination of participation in this Plan will automatically revoke the Participant's election. Reimbursements from the Health FSA and Dependent Care FSA after termination of participation will be made according to the COBRA provision described in Section 9.

3.3 Recommencement of Participation

If you terminate your employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then are rehired within 30 days or less after the date of a termination of employment, then you will be reinstated with the same election(s) that you had before termination. If you are rehired more than 30 days following termination of employment and are otherwise eligible to participate in the Plan, then you may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Benefit module will be reinstated only to the extent that coverage under the Group Insurance Benefits Plan (i.e. major medical, dental, etc) is reinstated.

Section 4: Schedule of Benefits

Benefits may be purchased through this Flexible Spending Plan with pre-tax income. Details relative to the cost per pay for each benefit and the minimum and maximum amounts you may contribute to the various benefit spending accounts are provided by Community High School District #155 on the enrollment form and outlined in Exhibit D of this Plan Document/Summary Plan Description.

An Eligible Employee enrolled in this Plan has the opportunity, available under Section 125 of the Internal Revenue Code, to save taxes on the following expenses:

- *Premium Payment:* Contributions deducted from your paycheck for Group Insurance Benefit Plan coverage sponsored by the Employer. ***Note:*** *While election to enroll in this benefit option may be made under this Plan, the benefits will not be provided by this Plan but by the Group Insurance Benefit Plan and therefore, subject to the terms of those plans.*

- *Health Flexible Spending Account:* Expenses incurred by you or your dependents for eligible medical, dental, vision services, and supplies, (or as allowable in accordance with Code § 213(d)) that are not reimbursed by the Group Insurance Benefit Plan, a health savings account, as defined under or Code § 223, or other plans, e.g. your spouse's employer's plan. The amount you select (up to a maximum of $5,000.00 per calendar year) is taken from your paycheck before taxes.

- *Dependent Care Spending Account:* Eligible dependent day care charges incurred for the care of a child (less than age 13) or a disabled spouse or disabled dependent (age 13 and over). Only expenses incurred during the hours that you and your spouse are working are eligible. The amount you select up to a maximum of $5,000.00 per calendar year if married and file federal income taxes jointly or $2,500.00 if married and file separately) is taken from your paycheck before taxes.

You may elect any or all of the benefits described above by completing a Section 125 Flexible Spending Account Enrollment Form and submitting to your human resources department by the deadline established prior to the beginning of each new plan year (January 1). If a Participant elects not to participate in the Plan, such Participant shall be deemed to have chosen the cash Benefit as his sole Benefit option

Each of the above benefits under the Flexible Spending Plan has separate rules governing benefits and plan administration. These rules are explained in this Plan Document/Plan Summary Description that have been prepared solely for the purpose of describing each particular benefit.

Section 5: The Premium Payment Benefit Component

The Premium Payment Benefit included in this Flexible Spending Plan applies to all Eligible Employee of the Employer making a contribution deducted from your paycheck to carry Group Insurance Benefit Plan coverage. **All Employees who have deductions from their Community High School District #155 paycheck for the Group Insurance Benefit Plan are automatically enrolled in this option unless they request otherwise.**

This portion of the Plan is a "Salary Reduction" plan. This means that you pay your share of the cost of your benefits by having your compensation reduced on a pre-tax basis. The amount of your elected salary reduction will be deducted from your gross income before federal and state taxes, which lowers your taxable income and increases your take-home pay.

NOTE: If you want your premium deducted on an after-tax basis, you must notify your human resources department during the open enrollment period prior to January 1 of the new plan year, unless you have a "status change" as defined in and accordance with Section 7 of this booklet.

Section 6: Health & Dependent Care Flexible Spending Accounts (FSAs)

There are some expenses you know you will have to pay for in the coming year; for instance, new eye glasses, medical and dental care expenses not covered by an insurance plan, or perhaps care for a child or an incapacitated dependent adult while you are at work. Normally, you would pay for these expenses with after-tax income. When electing one or both of these accounts, you will pay with pre-tax dollars thus reducing your taxable income and increasing your take home pay.

IRS regulations require that funds, which are deducted from your pay and deposited into a Flexible Spending Account (FSA), must be used to reimburse expenses incurred for services provided during that plan year while you are a participant; otherwise the funds are forfeited. Therefore, planning prior to your enrollment each year is the key to achieving maximum benefits. Materials to assist you in estimating your elected annual maximum will be provided to you during the open Enrollment Period of each new plan year.

NOTE: The pre-tax payroll deductions elected for FSA Benefits can be changed or discontinued only at the beginning of each new plan year (January 1) unless you have a "Change in status" as defined in and accordance with Section 7 of this booklet.

6.1 How Health FSAs and Dependent Care FSAs Work

You may establish spending accounts for predictable medical expenses including dental and vision care expenses and dependent care expenses. Once you have determined your annual predictable expenses for the period of time covered by the plan year, a portion of that amount may be paid for with pre-tax pay, deposited on a per pay basis to a Health FSA or Dependent Care FSA. The minimum and maximum pre-tax deferral allowed for each account type is shown on the enrollment form. The Internal Revenue Code Section 125 states that these balances cannot be combined or used for purposes other than for which they were originally intended.

Once you become eligible and have completed an enrollment form, you may file a claim for medical or dependent care expenses incurred during the plan year that have not been reimbursed under any other employer's Group Insurance Benefit Plan or accident plan. Upon receipt of the claim, the Claims Administrator (TBB) will process and you will be reimbursed the full amount of your eligible expenses up to your elected Health FSA pre-tax deferral amount. For a Dependent Care FSA reimbursement, you must have accumulated a sufficient credit balance in account in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent months as contributions are made from your paycheck.

6.2 The Health FSA

Under this category, eligible expenses (qualifying medical expenses, as defined Under Code § 213(d)) include reimbursement for deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care expenses. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed practitioner to qualify. Covered expenses *do not include* premiums paid for other Group Insurance Benefit Plan coverage, including plans maintained by the employer of a family member, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage. *See Exhibit B for a list of eligible expenses and Exhibit C for a list of non-eligible expenses.*

You must determine before the Plan year starts the predictable amount you will spend in out-of-pocket medical expenses. One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventative care, it is important not to overestimate your needs, as tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan year.

6.3 The Dependent Care FSA

Dependents are defined for this purpose as children under age 13, handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exception on your federal tax return. If dependent care is required to enable you (and your spouse) to work, these expenses may be eligible for reimbursement. Included are payments to childcare centers, nursery schools and pre-schools. Eligible expenses also include payment for summer day camps, before and after school care for kindergarten to age 13, and elderly care. Care within your home or a private individual's home is also eligible provided the individual is not a child under 19 nor are considered a dependent on your federal tax return. The provider of dependent care services must disclose their tax identification or social security number in order to claim dependent care services.

6.4 FSA Accounts – Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible reimbursement accounts.

- Compensation redirection authorized for medical and dependent care expense reimbursement is in effect for the entire year unless you have a Change in Status such as those listed in Section 7.2 of this Plan Document/Summary Plan Description.
- You must use all funds in your reimbursement accounts by the end of the plan year or you will lose them; the balances cannot be combined, carried over into next year, or converted to cash. So, if you choose to open a Health FSA or Dependent Care FSA it is wise to be conservative in your estimate of future reimbursable expenses.
- You will receive a quarterly statement throughout the course of the plan year to remind you how much is left in your account. This money must be used for expenses incurred before the end of the plan year or be forfeited. You may continue to submit claims until April 1st after the plan year ends for prior year's expenses.

How To File A Claim

(a) Debit Card Program

Special Substantiation procedures apply under IRS rules. Records must be kept in the form of receipts or other proof of payment to substantiate any debit card payments. Receipts from doctors and medical providers must how the date of the visit or service. Receipts for other

qualifying medical, dental or vision expenses must show the date and the type of medical service or supply. The receipts required will be the same type of receipts as required for paper claims as described above. If the debit card purchases do not have receipts that are satisfactory to the Plan Administrator or the IRS on request, the debit card holder can be required to repay the Plan. Debit cards are subject to Physician prescription requirement for over-the-counter drugs. If you intend to use the same Dependent Care Provider throughout the Plan Year, you can be required to submit your initial weekly or monthly expenses to the Flex Plan for a one-time verification. If your Dependent Care Provider or cost of care changes, you may need to re-verify prior to continuing use of the payment card.

(b) Submitting a Manual Claim
Upon enrollment in a Health FSA and/or Dependent Care FSA, you will be provided with a "Section 125 Health Reimbursement Claim Form" and/or a "Section 125 Dependent Daycare Claim Form." Complete the applicable claim form by providing your account information (i.e.name, address, social security number, etc.), your spouse and/or dependent's information, if applicable to the claim, and copies of the documentation substantiating your claim. This form may be mailed to the address on the claim form, emailed to fsa@groupadministrators.com or faxed (847-519-1979). The claim is reviewed and processed and reimbursement in the form of a check is mailed according to a schedule determined by your Employer. Checks are always and only made to the Participant and never made to a provider of services.

(b) Insurance claims. Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(c) Dependent Care FSA claims**.** Any claim for Dependent Care FSA Benefits shall be made to the Administrator. For the Dependent Care FSA, if a Participant fails to submit a claim within 90 days after the end of the Last Day of Plan Year, those claims shall not be considered for reimbursement by the Administrator. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(d) Dependent Care FSA Appeal. Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) Health FSA claims. If a Participant fails to submit a claim under the Health FSA within 90 days after the end of the Last Day of Plan Year, if applicable, those claims shall not be considered for reimbursement by the Administrator. However, for all other claims, once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

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

(2) Reference to the specific Plan provisions on which the denial was based.

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

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the claim determination;

(2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

Section 7: **Election Changes**

You generally cannot change your election to participate in this Plan or vary the Salary Reduction amounts that you have elected during the plan year (known as the irrevocability rule). Of course, you can change your elections during the open Enrollment Period, but that will apply only for the upcoming plan year.

During the plan year, there are several important exceptions to the irrevocability rule known as "Change in Status." Change In Status events do not apply for all benefits, and the applicable exclusions are described under the relevant headings below. In addition, the Plan Administrator can change certain elections on its own initiative.

If a Change in Status event occurs, you must inform the human resources department and complete a new enrollment form within thirty-one (31) days after the occurrence.

7.1 Leaves of Absence

You may change an election to your Salary Reduction upon FMLA, non-FMLA, and USERRA leaves of absence.

(a) *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 Group Insurance Benefit Plan and Health FSA benefit on the same terms and conditions as if you were still an active Employee (that is, your Employer will continue to pay its share of the premium payment to the extent that you opt to continue coverage).

You may elect to continue your coverage under the Premium Payment Benefit and/or Health FSA options during the FMLA leave. If you elect to continue coverage while on leave, then you may pay your share of the premium in one of the following ways: (1) with after-tax dollars, by sending monthly payments to the Employer by the due date the Employer establishes; (2) with pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave compensation. To pre-pay the premium, you must make a special election to that effect prior to the date that such compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next plan year); (3) under another arrangement agreed upon between you and the Employer (i.e., the Employer may fund coverage during the leave and withhold "catch-up" amounts upon your return).

If your coverage ceases while on an FMLA, you will be permitted to re-enter the Plan upon return from such leave on the same basis that you were participating in the Plan prior to the leave, or otherwise required by the FMLA

Non-Health Benefits. If you go on a qualifying leave under the FMLA, entitlement to non-health benefits (such as Dependent Care FSA benefit) is to be determined by the Employer.

(b) *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 apply.

(c) *Uniformed Service Employment and Reemployment Rights Act (USERRA).* If you are in a uniformed service, and you take an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRRA") you may revoke your election to participate under any benefit offered under this Plan, for the remainder of the plan year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon your return from your USERRA Leave, you may be reinstated in the Plan, on the same terms that applied to you prior to your taking the USERRA leave, and with such other rights to make enrollment changes as are provided to other participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan year in which the USERRA Leave commences, as other plan participants.

7.2 Change in Status

If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

(a) *Legal Marital Status*. A change in a your legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;

(b) *Number of Dependents*. A change in a number of dependents, including birth, death, adoption, placement of adoption, or death of a dependent;

(c) *Employment Status*. Any of the following events that change the employment status of you, your spouse, or your dependent and that affects benefits eligibility under a salary reduction plan or other employee benefit plan of you, your spouse, or your dependent. Such events include any of the following changes in employment status: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

(d) *Dependent Eligibility Requirements*. An event that causes a dependent to satisfy or cease to satisfy the dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, as applicable, or any similar circumstance, including any additional coverage eligibility for a child of the Employee through age 26; and

(e) *Change in Residence*. A change in the place of residence of the participant or his or her spouse or dependents. An election change is permissible where a change in residence affects the employee's eligibility for coverage. For example, an employee could not increase or decrease an election merely because he or she moved, unless as a result of the move the employee is no longer eligible for health coverage.

7.3 Change in Status – Other Requirements

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event even if the event affects coverage

eligibility. A Participant may change an election as described below upon the occurrence of the stated events for the applicable benefit option of this Plan:

(a) *Open Enrollment Period* (applies to Premium Payment Benefit, Health FSA and Dependent Care FSA benefits). You may change an election during the open Enrollment Period.

(b) *Termination of Employment* (applies to Premium Payment Benefit, Health FSA and Dependent Care FSA benefits) you will terminate under the Plan upon termination of employment in accordance with Section 3.2.

(c) *FMLA* (applies to Premium Payment Benefit, Health FSA and Dependent Care FSA benefits). You may change an election under the Plan upon FMLA leave in accordance with Section 7.1.

(d) *HIPAA Special Enrollment Rights* (applies to Premium Payment Benefit, but not to Health FSA or Dependent Care FSA benefits). If you, your spouse or dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801 (f), then you may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right.

i. You or your spouse or dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such other coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

ii. You have acquired a new dependent as a result of marriage, birth, adoption, or placement of adoption. An election to add previously eligible dependents as a result of the acquisition of a new spouse or dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement of adoption for a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to thirty-one (31) days).

(e) *Certain Judgments, Decrees and Orders* (applies to Premium Payment Benefit and Health FSA Benefits, but not to Dependent Care FSA benefits). If a judgment, decree, or order results from a divorce, legal separation, annulment or change in legal custody requires your child (including a foster child who is your dependent) to be covered under the Group Insurance Benefit Plan or Health FSA benefit, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

(f) *Medicare and Medicaid* (applies to Premium Payment Benefit, to Health FSA benefits as limited below, but not to Dependent Care FSA Benefits). If you, your spouse or dependent becomes entitled to (i.e. becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that individual's accident or health coverage under the Group Insurance Benefit Plan, and/or your Health FSA coverage may be canceled completely but not reduced. Similarly if you or your spouse or dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that individual's accident or health coverage.

(g) *Change in Cost* (applies to Premium Payment Benefit, to Dependent Care FSA benefits as limited below, but not to Health FSA benefits). If the cost charged to you or for your Group Insurance Benefit Plan or dependent care expense significantly increases during the Plan year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option that provides similar coverage, or elect similar coverage under the plan of your spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage.

(Note that for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Group Insurance Benefit Plan; (b) an HMO and a PPO are considered to be similar coverage; and (c) coverage under another employer plan, such as that of a spouse's or dependent's employer may be treated as similar coverage.

For insignificant increases or decreases in the cost of benefits, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator generally will notify you of increases in the cost of the Group Insurance Benefit Plan; you generally will have to notify the Plan Administrator of increases in the cost of dependent care expenses. The change in cost provision applies to dependent care expenses only if the cost change is imposed by a dependent care provider who is not your relative.

(h) *Change in Coverage* (applies to Premium Payment Benefit and Dependent Care FSA benefits, but not to Health FSA benefits). You may change your election if one of the following events occurs:

i. Significant Curtailment. If your Group Insurance Benefit Plan coverage or dependent care expense is significantly curtailed *without* a loss of coverage then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. If your Group Insurance Benefit Plan coverage or dependent care expense is significantly curtailed *with* a loss of coverage then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your spouse's employer or drop coverage but only if there is no option available under the plan that provides similar coverage. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a loss of coverage has occurred.

ii. Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage, the Plan adds a new benefit package option or significantly improves an existing benefit package option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit Eligible Employees to elect the new or improved option on a prospective basis, subject to the limitations imposed by the applicable option.

iii. Loss of Other Group Health Coverage. You may change your election to add group insurance coverage for you, your spouse or dependent, if any of you lose coverage under any group insurance coverage sponsored by a governmental or education institution, for example, a state children's group insurance program.

iv. Change in Coverage Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under an employer plan (including a plan of the employer of a plan or the spouse's or dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under applicable IRS regulations; or (b) the Salary Reduction plan permits you to make an election for a period of coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election to drop coverage is made by your spouse during his or her employer's open enrollment, you may add coverage to replace the dropped coverage.

v. Dependent Care FSA Coverage Changes. You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

(i) *Modifications Required by the Plan Administrator.* The Plan Administrator may modify your election(s) downward during the Plan year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Salary Reduction 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 Salary Reduction plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

Section 8: Miscellaneous Information Regarding FSAs

8.1 About Social Security Taxes

Social security taxes are not deducted from the amount you pay in premiums on a pre-tax basis. This could result in a small reduction in the social security benefit you receive at retirement. This is because social security benefits are based on the amount earned while you were working, up to the "taxable wage base" (TWB). The TWB is adjusted annually. If your compensation is above the TWB, your social security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through this Flexible Spending Plan may offset any possible reduction in social security benefits.

8.2 Qualified Medical Child Support Orders

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (a) creates or extends the rights of an "alternate recipient" to participate in a group insurance plan, including this Plan, or (b) enforces certain laws relating to medical child support. An "alternate recipient" is any child or a Participant who is recognized by a medical child support order as having a right to enrollment under the Participant's Group Insurance Benefit Plan.

A medical child support order will outline certain specific conditions to be qualified. The Plan Administrator will notify you if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

8.3 Amendment, Termination and Future of the Flexible Benefits Plan

The Flexible Spending Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you are entitled before the date of the amendment or termination.

Section 9: Continuation of Coverage (COBRA)

In general, the following provisions shall apply to benefits provided to eligible employees and their dependents under the Plan. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

9.1 The Health FSA Benefit Plan

The provisions of COBRA allow you to continue participation in a Health FSA on an after-tax basis, if your participation ceases, and at the time of termination you have a ***positive*** balance in your account (taking into account all claims submitted before the date of the qualifying event). To the extent required by COBRA, you, your spouse or qualifying dependents, whose FSA coverage terminates because of a COBRA qualifying event, will be given the opportunity to continue on an after-tax, self-pay basis.

You will be notified in writing of your rights to continue coverage when your employment terminates or when a reduction in the number of hours worked per week occurs. Your spouse or dependents will be notified in writing of their rights if you should die. You have a period of 60 days during which to decide if you, your spouse or dependents want to continue participation. Information about the cost of the continued coverage and the election procedures will be provided when you, your spouse or dependents become eligible to apply. ***NOTE: Dependent Care FSAs are not eligible for COBRA.***

Section 10: Plan Administration

10.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator, the Employer, and Community High School District #155. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the persons entitled to participate in this Plan without discrimination among them. All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

The Employer has appointed Group Administrators, Ltd. (GAL) whose address is 915 National Parkway, Suite F, Schaumburg IL 60173 and whose telephone number is 847-519-1880 as Claims manager/administrator (the "Claim Administrator"), who serves the Plan Administrator in a delegated, non-fiduciary, capacity.

10.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have full and exclusive rights to administer and/or interpret the Plan and to decide all matters there under, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) To construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;
(b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
(c) To prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate;
(d) To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
(e) To furnish each Employee and Participant with such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's compensation has been reduced in order to provide benefits under this Plan;
(f) To receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
(g) To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
(h) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
(i) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
(j) To maintain the books of accounts, records and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

10.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that

are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

10.4 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

10.5 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

10.6 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

10.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

10.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

10.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 of the regulations issued there under, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer.

10.10 Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

10.11 Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

10.12 Exclusive Benefit

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

10.13 Participants Rights

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

10.14 Action by the Plan Administrator

Whenever the Plan Administrator under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority, including any such acts delegated to the Claims Administrator.

10.15 Employer's Protective Clauses

(a) Insurance purchase. Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) Validity of insurance contract. The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

10.16 No Guarantee of Tax Consequences

Neither the Claims Administrator nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

10.17 Indemnification of Plan Administrator by Participants

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Plan Administrator for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.18 Funding

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

10.19 Governing Law

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Plan Administrator guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Illinois.

10.20 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

Section 11: Your Privacy Rights Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines "Protected Health Information" (PHI) as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present or future payment of the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

The HIPAA definition of PHI applies to this Plan and it restricts a Plan Administrator's use and disclosure of PHI. The Plan Administrator shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA, subject to the conditions of permitted disclosure and after obtaining written certification. The Plan may disclose PHI to the Plan Administrator, provide that the Plan Administrator uses or discloses the PHI for plan administration purposes only. Plan administration purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as, claims processing, auditing, and monitoring.

11.1 Plan Sponsor Obligations

Where PHI use and disclosure and Electronic PHI use and disclosure will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the manual and electronic PHI as follows:

(a) The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the manual and electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

(b) The Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

(c) The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides manual or electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and

(d) The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   i. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's manual or electronic PHI; and

   ii. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request."

Section 12: Statement of ERISA Rights

As a Participant in Community High School District #155 Flexible Spending Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan *Participants* shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

(b) Obtain copies of all plan documents, insurance contracts, and other information, if any, and copies of the latest annual report. The Plan Administrator may make a reasonable charge for copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for plan participants ERISA imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of participants and beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, then claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials 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 per pay until they are received, unless the materials were not sent due to reasons beyond the Plan Administrator's control.

If you have a claim for benefits that are denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if under the Plan you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if for example, it finds your claim is frivolous.

If you have any questions about your Plan should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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.

The right is reserved in the Plan for the Plan Administrator to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan. This Community High School District #155 Plan Document/Plan Summary Description governs specific rights to benefits under this Plan solely and in every respect.

Exhibit A: Flexible Spending Plan Questions and Answers

1. ***Q: What benefits are offered through the Plan?***
   A: Two elected benefits are offered under the Plan: Health Flexible Spending Account and a Dependent Care Flexible Spending Account. The Premium Payment Benefit is an automatic deduction at the time of enrollment in the Group Insurance Benefit Plan.

2. ***Q: What is the Premium Payment Benefit?***
   A: The Premium Payment Benefit enrollment is automatic at the time of your Group Insurance Benefit Plan enrollment. Community High School District #155 will deduct your share of the Group Insurance Benefit Plan premiums and other ancillary benefits with *pre-tax* dollars. *If you want to have your premium deducted on an after tax basis, you must notify your human resources department when you are newly eligible or during any subsequent open enrollment period prior to January 1 of the new plan year.*

3. ***Q: How do the Health FSA and Dependent Care FSA programs work?***
   A: Once you have determined your annual predictable medical or dependent care expenses for the plan year (or part thereof, if you first become eligible to participate in the middle of a plan year), you may elect to defer a portion of your salary into a Health FSA or Dependent Care FSA maintained on your behalf. You must complete an enrollment form that authorizes the Employer to reduce your pay on a pre-tax basis.

   The annual total you select for your Health FSA and/or Dependent Care FSA will be divided by the number of pay checks you receive in the calendar year.

4. ***Q: What is the advantage of having a Health FSA or Dependent Care FSA?***
   A: The purpose of flexible spending accounts is to save taxes. By using one (or both) of these accounts you will not be paying federal and state income taxes as well as social security taxes on the income used to pay for eligible health care and dependent day care expenses. The following examples represent the tax savings that can be generated.

After Tax VS. Pre-Tax – *Example 1*

Assumptions:		
1.	Annual Taxable Earnings	$30,000
2.	Annual Health FSA Deposit	500
3.	Federal, State, & FICA Tax Rate	25.65%

	AFTER-TAX	**PRE-TAX**
Annual Taxable Earnings	*$30,000*	*$30,000*
Less Pre-Tax Health Care Expenses	*0*	*500*
Taxable Income	***$30,000***	***$29,500***
Less Estimated Income Taxes	***7,695***	***7,567***
Annual Income After Taxes	*22,305*	*$21,933*
Less After-Tax Health Care Expenses	*500*	*0*
Spendable Income	***$21,805***	***$21,933***

This employee has increased annual take home pay by $128.00 using an FSA.

After Tax VS. Pre-Tax – *Example 2*

Assumptions:		
1.	Annual Taxable Earnings	$60,000
2.	Annual Health FSA Deposit	1,000
3.	Annual Dependent Care FSA Deposit	5,000
4.	Federal, State, & FICA Tax Rate	38.65%

	AFTER-TAX	**PRE-TAX**
Annual Taxable Earnings	*$60,000*	*$60,000*
Less Pre-Tax Health & Dependent Day Care	*0*	*6,000*
Taxable Income	***60,000***	***$54,000***
Less Estimated Income Taxes	***23,190***	***20,871***
Annual Income After Taxes	*$*36,810	$33,129
Less After-Tax Health & Dependent Day Care	*6,000*	*0*
Spendable Income	**$30,810**	***$*33,129**

This employee has increased annual take home pay by $2,319.00 using these FSAs

5. Q: What kind of expenses can I pay from a Health FSA?

A: Services and supplies reimbursable from your Health FSA include those not paid by the Employer's Group Insurance Benefit Plan (or other coverage plans i.e., your spouse's plan) such as deductibles and co-payments, and those expenses not eligible under an insurance plan but considered deductible by the IRS. Examples of services and supplies not reimbursed by your Group Insurance Benefit Plan may include over-the-counter reading glasses, LASIK eye surgery, supplies and over-the-counter drugs, vitamins, herbs, and minerals **prescribed by a physician** to treat an illness, injury, or condition.

NOTE: *Only expenses incurred for services received or supplies ordered during the plan year, January 1 (or your effective date) through December 31 (or your termination date) are eligible for reimbursement.*

6. Q: What kind of expenses can I pay from a Dependent Care FSA?

A: You can be reimbursed from your Dependent Care FSA for expenses associated with the care of dependents while you and your spouse are working. Most types of dependent care services are covered, including care in your home or in a licensed dependent care facility such as a day care center. **You must provide the social security or tax identification number of the provider of service when requesting reimbursement.**

NOTE: *Only expenses incurred for services received during the plan year (January 1 through December 31) are eligible for reimbursement. If your participation begins after January 1 and/or terminates prior to December 31, only expenses incurred from your effective date through your termination date are eligible.*

7. Q: How do I submit a claim?

A: Once you have an account, claims for eligible expenses are submitted to reimburse the funds you have placed into your account. For a Health FSA, you may advance on your maximum at any point during the Plan year. For a Dependent Care FSA, you will only be reimbursed for your balance to date, and any remaining portion will be considered upon a new deposit of your scheduled deduction. The claim is then submitted to your Claims Administrator (GAL) by using the Section 125 Flexible Spending Account claim forms provided. There is a separate form for the Health FSA and Dependent Care FSA. Each time a claim is processed you will be given the current status of your account.

8. Q: Will the Health FSA claims I submit to my Claim Administrator be kept private?

A: Yes. The new HIPAA Rule requires that Protected Health Information (PHI) given to the Claim Administrator be kept completely confident

9. Q: If I participate in the Dependent Care FSA will I still be able to claim the household and dependent care credit on my federal income tax return?

A: You may not claim any other tax benefit for the tax-free amounts received by you under this Plan. However, the balance of your dependent care expenses not eligible for reimbursement under this Plan, if any, may be eligible for the dependent care credit.

10. Q: Is the Dependent Care FSA going to generate more savings for me than the child and dependent care tax credit I can take on my federal tax return?

A: The answer to this question depends on several variables, e.g., the number of dependents receiving care, the cost for the care and your adjusted gross income. Information will be provided to help you evaluate these alternatives during the annual Enrollment Period of each new plan year. Also, it is advisable to consult with your tax advisor before deciding which choice is best for you.

11. Q: Can I change the amount(s) of my reduction during the plan year?

A: You can only change or stop your reduction if you have a "Change in Status" during the plan year as described in Section 7. **Note: Your election change must be submitted in writing to the Employer within thirty-one (31) days of the Change in Status and must be on account of and correspond with the Change in Status.**

12. Q: Are there any potential disadvantages?

A. **If you don't use all of the money you deposit during the plan year you cannot get it back.** Careful estimating should avoid this problem. Also, you cannot change the amount of your election during the plan year unless you have a "Change in Status". Finally, the reduction in your FICA wages may slightly reduce your survivor and disability benefit because the tax-savings you receive through this program reduces the amount you contribute toward your social security benefit.

13. Q: How can I avoid the possibility of losing money?

A: Carefully estimation of your expenses is the only way to avoid losing money. Reviewing your family's medical expense history might be helpful and, of course, some expenses are predictable. Routine medical exams, orthodontia, eyeglasses, or contact lenses are good examples for the Health FSA, and dependent day care needs and expenses are usually easy to forecast. Using these accounts can save hundreds of dollars on these expenses because you are paying for them with before-tax dollars.

14. Q: Why can't I get my money back if there's any left in my Account?

A: IRS regulations do not allow the Employer to return the money.

15. Q: Can I carry money left in an Account over to the next plan year?

A: No.

16. Q: What happens to the money left in my Account that I have to forfeit?

A: It will be used by the Employer to offset the claims administration cost of the program.

17. Q: Can I transfer money between the Health FSA and the Dependent Care FSA?

A: No, the IRS will not allow a transfer.

18. Q: Can I earn interest on the money deposited in my Account?

A: No. The IRS does not permit interest on these accounts.

19. Q: What happens if I take a leave of absence or if I'm on a disability leave?

A: If you are on a paid leave of absence receiving regular paychecks your deductions will continue. If you are on an unpaid leave of absence, you can terminate from the program because an unpaid leave of absence is a "Change in Status." If you wish to extend participation beyond the receipt of regular paychecks you will be able to do so through COBRA (Section 9). *See Section 7.1 for FMLA leave of absence details.*

20. Q: What happens to the remaining funds in my Health FSA and/or Dependent Care FSA if I leave the Employer before the plan year ends?

You have the following options:

1) You may continue to submit expenses <u>incurred prior to your termination date</u> to the Claims Administrator until the account balance for the plan year is used.
2) If you terminate before all your contributions have been deducted <u>and</u> you anticipate using the ***positive*** balance in your Health FSA for services provided after your termination date, you may continue your eligibility through a COBRA extension (see Section 9).
   Note: *COBRA does not apply to the Dependent Care FSA.*
3) If you do not choose option 1 or 2, any money remaining in your account after you leave the Employer will be forfeited.

Exhibit B: Health FSA Eligible Expenses

(Including but not limited the following list)

1. Expenses covered by the Employer's Group Insurance Benefit Plan or other plans such as your spouse's employer's plan(s) but not reimbursed because of the deductible or co-payments.

2. Expenses that **may not** be covered by your Group Insurance Benefit Plan, including but not limited to:

- Charges in excess of reasonable and customary expenses.
- Vision expenses above and beyond what your Group Insurance Benefit Plan may cover (including eyeglasses, contact lenses, and optometrist) as well as the cost of contact lens solutions, LASIK eye surgery, guide dog for the blind and special education devices for the blind.
- Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy.
- General physical exams, immunizations and well baby care.
- Cosmetic procedure(s) and related supplies/prescriptions if it 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 disfiguring disease.
- Services for chromosome or fertility studies.
- Treatment (other than surgery, which may be covered by the Group Insurance Benefit Plan) of corns, bunions, calluses, foot structural disorders, etc.
- Ace bandages, support hose, or other pressure garments that have been prescribed by a physician.
- Acupuncture for pain relief as performed by a licensed practitioner.
- Smoking cessation programs that are prescribed by a physician as well as related drugs that can only be purchased with an FDA approved prescription.
- Weight loss program/prescriptions drugs that are prescribed by a physician to treat an illness (the cost of special foods is not eligible). A letter of medical necessity from your physician is required to substantiate this expense.
- Over-the-counter drugs purchased to treat an illness, injury, or condition. For taxable years beginning after 12/31/10 a health FSA will not be able to reimburse over the counter medicines or drugs (other than insulin) without a doctor's prescription.
- Vitamins, minerals, herbs, and supplements prescribed by a physician to treat an injury, illness, or condition. Note: These expenses require a letter of medical necessity from the prescribing physician.
- Band-aides, gauze pads, first aid kits, cold/hot packs, for injuries.
- Individual psychiatric or psychological counseling.

- Orthodontic services (Note: The total cost of the total orthodontic treatment can only be reimbursed so long as the employee has actually made the payment in advance in order to receive the services. Orthodontic reimbursement will require a claim form, a coy of the contract, statement of receipt representing payment in full and any/all insurance explanation of benefits worksheets)

- Transportation expense to receive medical care including fares for public transportation as well as mileage, parking expenses, and tolls when using your personal vehicle. (Mileage is calculated at the IRS standard rate per mile). Transportation requests must be submitted along with the bill that supports the need for transportation (physician or hospital bill for example) along with a document supporting the mileage such as a Map Quest printout.

- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf.

- Birth control pills and other birth control over-the-counter supplies or legally induced abortions.

- Hypnosis for treatment of an illness.

- "Halfway house" care to help individuals adjust from life in a mental hospital to community living.

- Tutoring by licensed therapist for a child with a severe learning disability and special schooling for handicapped.

- Lifetime care advance payment to private institution for lifetime care, treatment, or training of mentally or physically handicapped patient.

- Medical information plan fees paid to a plan maintaining individual's medical information by computer.

- Special car controls for the handicapped.

- Reimbursement may also be made, at least in part, for certain capital expenditures that are made primarily for health care reasons. For example, an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement. Another example might be the installation of an exercise swimming pool to aid in the recovery of a stroke victim. You must provide proof of the medical necessity for these types of expenses. It is HIGHLY recommended that you consult with the Claims Administrator regarding eligibility of such items before including them in your election.

The above notwithstanding, if the Participant and/or his or her Spouse or other Dependent(s) are considered as an Eligible Individual who contributes to a qualifying Health Savings Account in accordance with Code § 223(c), the Medical Care Expenses otherwise payable by this Plan shall be paid through the Health Savings Account or High Deductible Health Plan, as applicable, and the only expenses eligible for reimbursement under your Health FSA Account are limited to dental, vision and any other expenses not otherwise covered or paid for through your Health Savings Account or High Deductible Health Plan in accordance with Code § 223(c).

Exhibit C: Health FSA Non-Eligible Expenses

(Including but not limited the following list)

- Marriage or family counseling.
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth).
- Cosmetic procedures, supplies, and prescriptions that are performed/provided solely for cosmetic purposes.
- Maternity clothing, nursing bras and baby hygiene products such as diapers, wipes, etc.
- Household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework).
- Custodial care in an institution.
- Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods.
- Health club dues, YMCA dues, etc. that are not prescribed by a physician to treat an illness or an injury.
- Social activities, such as dance lessons or classes (even though recommended by a qualified physician for general health improvement).
- Membership fees or costs associated with weight-loss programs for general health and well-being purposes.
- Teeth bleaching for cosmetic purpose. *(If discoloration is due to an illness or an injury then this may be eligible).*
- Cosmetics, toiletries, personal hygiene products, toothpaste, etc.
- Vitamins taken for general health purposes and/or can be purchased without an FDA approved prescription.
- Contributions for other group or individual insurance coverage, such as premiums.
- The segment of automobile insurance contributions providing medical coverage for persons injured through an accident involving an employee's car.
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect.

Exhibit D: Plan Administrative Information

GENERAL PLAN INFORMATION:

Plan Name:	Community High School District #155 Flexible Spending Plan
Plan Number:	502
Effective Date:	January 1st, 2003
Plan year:	January 1st thru December 31st and each subsequent 12-month calendar year period thereafter
Type of Plan:	Welfare Plan providing Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits
Type of Administration:	Employer Administration
Plan Funding:	Claims paid from general assets of Employer
Health FSA Maximum	$5,000.00
DCAP Maximum	$5,000.00
Claim Submittal Deadline:	April 1st

EMPLOYER/PLAN ADMINISTRATOR INFORMATION:

Community High School District #155
One S. Virginia Road
Crystal Lake, IL 60014
1-815-455-8505

Tax ID # 366005124

SERVICE OF LEGAL PROCESS

The name and address of the Plan's agent for service of legal process are:

Community High School District #155
One S. Virginia Road
Crystal Lake, IL 60014

CLAIMS ADMINISTRATOR:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
Phone: 847-519-1880
Fax: : 847-519-1979

The Claims Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Claims Administrator will also answer any questions you may have about our Plan. You may contact the Claims Administrator for any further information about the Plan.

CERTIFICATE OF ADOPTION

On behalf of Community High School District #155 I certify that the Community High School District #155 Flexible Spending Plan Document Summary Plan Description is restated effective January 1, 2012.

Signature

Title

Date