

# **SUMMARY PLAN DESCRIPTION**

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**Plano Independent School District**

**Flexible Benefit Plan**

**Including the Dependent Care Assistance Plan  
and the Medical Reimbursement Plan**

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# INTRODUCTION TO THE PLAN

## **In General**

Effective January 1, 2008, the Plano Independent School District (the District) amended its flexible benefit plan. The plan is still called the Plano Independent School District Flexible Benefit Plan (the Plan), and the Plan contains the same features as the prior plan with several minor changes.

The revised Plan, like the prior plan, allows you to pay for your portion of the costs under certain of the health plans sponsored by the District on a pre-tax basis. The Plan also continues to permit you to pay for certain other medical and dependent care expenses on a pre-tax basis. The benefit to you of paying these expenses on a pre-tax basis is that your federal income taxes may be lowered.

*This summary plan description summarizes the most significant terms of the Plan. This summary is not the official Plan document. In the event of any conflict, inconsistency, or ambiguity between this summary and the official Plan document, the terms of the official Plan document will be controlling.*

## **Participation**

If you are an employee who is in a permanent status (as defined by the District) and regularly scheduled to work at least 25 hours per week and eligible to participate in the Plano Independent School District Employee Health Benefit Plan, or if you are regularly scheduled to work less than 25 hours per week but you participate in any of the medical options, you are eligible to participate in this Plan. As part of the Plan enrollment process, you will be given an enrollment form. You must complete, sign and return the form in order to participate in the medical expense reimbursement or dependent care portion of the Plan. Unless you complete and return the form and specifically elect not to participate in the Plan, however, your portion of the premiums for the health plans covered by the Flexible Benefit Plan will automatically be deducted from your compensation on a pre-tax basis.

If your employment with the District ends and you are later rehired, you will be treated as a new employee for purposes of determining your eligibility to participate in the Plan.

## **Pre-Tax Premium Plan**

Unless you elect not to participate and except as otherwise described in this summary, your portion of the premiums for certain health plans sponsored by the District will be deducted from your compensation on a pre-tax basis. The health plans sponsored by the District that are included in the pre-tax premium portion of the Plan are:

- The Plano Independent School District Employee Health Benefit Plan
- The Vision Service Plan

For more information regarding those plans, please refer to the Plano Independent School District Employee Health Benefit Plan document. Please see the Questions and Answers section of this Plan summary for more information on the pre-tax premium portion of the Plan.

## **Medical Reimbursement Plan**

The Medical Reimbursement Plan allows you to set aside a fixed amount of your pay on a pre-tax basis in order to pay for eligible medical expenses. Such expenses would include deductibles and coinsurance payments that you would otherwise have to pay on a post-tax basis. As described in the Questions and Answers section below, in some cases you may be required to pay contributions on an after-tax basis.

In order to participate in this portion of the Plan, you will need to complete an enrollment form each year. On the form you will specify the amount of your pay you wish to redirect into your Medical Reimbursement Account for that year. The maximum amount you are permitted to redirect to your Medical Reimbursement Account is \$4,998 per year.

You will be permitted to file claims for eligible medical expenses for which you have not already been reimbursed from insurance or some other source. There is no minimum claim amount. Claims for medical expenses incurred during a calendar year may be filed up to April 30 of the following year, except as described in Question 24 if you cease participation.

**NOTE:** It is important to know that any unused amounts remaining in your account after you have submitted your eligible claims for a year will be forfeited and cannot, by law, be returned to you. Therefore, it is very important to carefully select the amount of your pay to redirect to your Medical Reimbursement Account; once the year begins, there are only limited instances that would allow you to change the amount of your election.

Please see the Questions and Answers section of this Plan summary for more information on the Medical Reimbursement Plan.

## **Dependent Care Assistance Plan**

Similar to the Medical Reimbursement Plan, the Dependent Care Assistance Plan allows you to set aside a fixed amount of your pay on a pre-tax basis to pay for eligible dependent care expenses. You will need to complete an enrollment form to elect the amount of your pay you wish to redirect to your Dependent Care Assistance Account. The amount will be deducted from your regular pay during the year and credited to your Account. The maximum amount of your pay you are permitted to redirect to your Account each year is \$4,998 (\$2,499 if you are married and elect to file a separate return from your spouse). As described in the Questions and Answers section below, in some cases you may be required to pay contributions on an after-tax basis.

You will be permitted to file claims as you incur eligible dependent care expenses. The minimum claim amount is \$25 (except that your final claim for the year may be for less than \$25). Claims for eligible dependent care expenses incurred during a calendar year may be filed up to April 30 of the following year, except as described in Question 24 if you cease participation. The maximum amount you may be reimbursed for eligible expenses is the balance of your Dependent Care Assistance Account.

**NOTE:** Just as under the Medical Reimbursement Plan, any unused amounts in your Dependent Care Assistance Account after all of your eligible claims have been submitted for a year will be forfeited. In addition, it may be more to your benefit to take the dependent care tax credit on your tax return rather than to use the Dependent Care Assistance Plan. Finally, please note that although the Medical Reimbursement Plan and the Dependent Care Assistance Plan are similar, your Account under each Plan is separate. By law, you are not permitted to use money in one Account to pay expenses incurred eligible for reimbursement from the other Account.

Therefore, it is very important to carefully select the amount of your pay to redirect to each of your Accounts; once the year begins, there are only limited instances that would permit you to change the amount of your election for the year.

Please see the Questions and Answers section of this Plan summary for more information on the Dependent Care Assistance Plan as well as the other features of the Plano Independent School District Flexible Benefit Plan.

The following Questions and Answers section discusses in more detail the features of the Plan and how the Plan operates.

# QUESTIONS AND ANSWERS

## I. Introduction

The District is pleased to sponsor the Plan for you and your fellow eligible employees. The Plan, commonly referred to as a cafeteria plan, allows you to make premium payments to certain District-sponsored plans, and pay for other eligible health care expenses and eligible dependent care expenses with before-tax deductions from your compensation from the District.

This Summary Plan Description describes the basic features of the Plan, how it operates and how you can get the maximum advantage from it. This Summary Plan Description is an easy-to-understand, non-technical explanation of the Plan and a brief description of your rights as a participant. It is not a part of the official Plan document.

A copy of the Plan document is available from the Plan Administrator. You may examine it at any time during normal working hours. If any information in this Summary Plan Description is in conflict with the Plan document, the provisions of the Plan document will control.

## II. General Information About the Plan

### Q.1 What is the purpose of the Plan?

The Plan is intended to qualify as a nondiscriminatory salary reduction "cafeteria plan" under the Internal Revenue Code of 1986, as amended ("Code"). The Plan gives you the flexibility of choosing between non-taxable benefits (such as health insurance, dependent care assistance and/or medical reimbursement) through the plan's salary redirection option and taxable benefits (such as cash).

### Q.2 What is meant by salary redirection?

Under salary redirection, you are allowed to redirect a portion of your taxable salary in order to receive non-taxable benefits. As a result, you select the benefits that best fit your personal needs while saving tax dollars.

The District in its sole discretion determines the manner in which your share of the cost of selected optional benefits will be allocated and deducted from your compensation during the Plan Year. The District may require allocation of the cost over fewer than all of the pay periods during the year (for example, contributions for food service and transportation division employees are deducted over pay periods exclusive of summer break, when those employees generally do not receive compensation). If you terminate employment and participation with a net contribution credit balance, the excess contributions (contributions relating to periods after your termination of employment and participation) will be refunded to you. Any refunded amount will be treated as taxable compensation.

Any required contributions for a pay period that exceed your compensation for that pay period (as reduced to account for any District required reserve and any other legally required or higher priority deductions) must be paid by you on an after-tax basis. Also, you will be billed on an after-tax basis for any required contributions that you do not make because you terminate employment or participation before the end of the year (for

example, if you are a food service or transportation division employee and you do not return or terminate after the summer break). If you do not pay any required contributions on an after-tax basis, your coverage under the District-sponsored plans will be retroactively terminated as of the last day of the month immediately preceding the month for which you failed to pay all or any portion of the required contribution.

### **Q.3 How does the Plan save you money?**

By allowing you to pay for certain benefits with pre-tax income, the Plan may reduce the amount you must pay in federal income taxes.

Said another way, the dollars you spend to pay for your portion of your District-sponsored plans (or for other medical expenses or dependent care) are ordinarily taxable. If you contribute a portion of your pay to the Plan through the Plan's salary redirection option to cover these expenses, the tax laws provide that you do not have to report that money on your federal income tax return, so you save federal income tax on that money. Therefore, you can use this savings for other things.

**EXAMPLE:** If you spend \$2,000 per year for your District-sponsored health care plan premiums, other medical expenses or dependent care expenses, this \$2,000 ordinarily has federal income tax withheld from it. However, if you agree to have this \$2,000 of your salary and wages placed in the Plan to cover the cost of your District-sponsored health care plan premiums, other eligible health care expenses or eligible dependent care expenses, you will not pay federal income tax on this \$2,000. Assuming you are in the 15% federal tax bracket, you would save 15% on this \$2,000, or \$300. If you are in the 28% federal tax bracket, you would save \$560. Your actual savings will vary depending on your personal tax situation. The Plan does not guarantee any tax consequences.

### **Q.4 What benefit options will be provided in the Plan?**

The District is offering you three benefit options to help you save on taxes. You may elect to participate in any, all or none of the following benefit options:

- Payment of your portion of the premium cost of the District-sponsored plans as specified earlier in this Summary Plan Description ("District-sponsored Plans");
- Reimbursement of other eligible health care expenses through the "Medical Reimbursement Plan"; and
- Reimbursement of eligible dependent care expenses through the "Dependent Care Assistance Plan".

### **Q.5 Will participation in the Plan affect your Social Security benefits at retirement?**

Since you are not covered by Social Security at Plano ISD, participation in this Plan will have no effect on any Social Security benefit you may be entitled to receive as a result of your employment with another employer.

**Q.6 Will participation in the Plan affect your other employee benefits provided by the District, your benefit under the Teachers' Retirement System, or the amount of your contributions toward your individual tax-deferred arrangement (403(b))?**

Generally, no. When you make salary redirection contributions to the Plan with pre-tax dollars, you lower your taxable income. This does not, however, affect any of your other employee benefits that are based on the amount of your pay, such as your life insurance or disability insurance. Your salary redirection contributions will not affect the amount of your benefit you ultimately receive from the Teachers' Retirement System or generally the amount you contribute to your individual tax-deferred arrangement. However, the maximum amount you are allowed to contribute to your individual tax-deferred arrangement is generally based on a percentage of your compensation. Compensation for this purpose is equal to your compensation reduced by amounts you salary redirect to the Plan. Therefore, participation in the Plan could reduce the maximum amount you are permitted to contribute to your individual tax-deferred arrangement.

**Q.7 Will payment of dependent care expenses through the Plan affect your ability to use the federal tax credit for dependent care expenses?**

Yes. Under current law, you can receive a tax credit on your federal income tax return for eligible dependent care expenses. However, you cannot receive both the tax credit and the advantages of the Dependent Care Assistance Plan for the same expenses. The dollar limit on the amount allowable as a tax credit is reduced, dollar-for-dollar, by any amounts reimbursed through the Dependent Care Assistance Plan. In some situations, the tax credit will be more valuable to you. In others, the Dependent Care Assistance Plan will produce a greater benefit. Or, a combination of the two might be best.

Deciding whether to use the Dependent Care Assistance Plan or the federal dependent care tax credit, or both, is complicated. The decision is based on your adjusted gross income (from your federal income tax Form 1040). You should determine if the tax credit is of more value to you than participation in the Dependent Care Assistance Plan before you make your salary redirection election. The tax credit and related income limits increased effective January 1, 2003. Therefore, the tax credit may be a better option for some or all of your dependent care expenses even if you previously did not use the credit.

### **III. Eligibility for Plan Participation**

**Q.8 Who can participate in the Plan?**

You are eligible to participate in the Plan if you are an employee who is in a permanent status (as defined by the District) and regularly scheduled to work at least 25 hours per week and eligible to participate in the Plano Independent School District Employee Health Benefit Plan, or if you are regularly scheduled to work less than 25 hours per week but you participate in any of the medical options. Those employees who actually enroll and participate in the Plan are called "Participants."

**Q.9 How do you enroll and become a participant in the Plan?**

**Pre-Tax Premium Plan** - Your participation in the Pre-Tax Premium Plan is automatic, provided you have enrolled and are participating in any of the District-sponsored Plans. If you do not want to be a Participant in this Plan, you must check NO on the Flexible Benefit Plan form. You may do so either at the time you enroll in the District-sponsored Plan, or during the annual enrollment election period prior to January 1 of each year.

**Medical Reimbursement Plan and/or Dependent Care Assistance Plan** - You must decide and elect before the start of each year the amount of your taxable compensation that you want to redirect and receive as nontaxable benefits. Separate elections must be made for the Medical Reimbursement Plan and the Dependent Care Assistance Plan. Before you enroll, you should first determine your projected eligible healthcare expenses and dependent care expenses for the upcoming year (or partial year for eligible employees hired after the annual enrollment election period). Keep in mind that these accounts are separate from one another - for example, you cannot be reimbursed for dependent care expenses through your Medical Reimbursement account. Also, each account is voluntary. So you can elect salary redirection contributions to just the Medical Reimbursement Plan or to just the Dependent Care Assistance Plan, or you can elect to contribute to both Plans or to neither Plan.

**When you decide on the amount you will contribute by salary redirection to each Plan, it is important that you make a careful and conservative estimate of what your eligible expenses might be, because any amounts left in either account at the end of the year are forfeited.**

Then you must complete a Flexible Benefit Plan form indicating how much you wish to contribute to each account and authorizing salary redirection. You may do so either as a new employee prior to your effective date in order to become a Participant for the remainder of the current year, or during the annual enrollment election period prior to January 1 of each year in order to become a Participant for the upcoming year. You will become a Participant when you have met the eligibility requirements and enroll in the Plan.

**Q.10 When is the annual enrollment election period?**

Prior to the start of each year, there will be an annual enrollment election period during which you may enroll in the Medical Reimbursement and/or Dependent Care Assistance Plans and make your contribution elections for the upcoming year. You may also decline to participate in the Pre-Tax Premium Plan at this time, as previously mentioned. The District will announce the dates of the enrollment election period each year before the period begins.

**Q.11 What is the minimum and maximum annual salary redirection contribution you can elect?**

Your annual election to the Medical Reimbursement Plan and/or the Dependent Care Assistance Plan can be in any whole dollar amount not less than \$300. The maximum amount that you may elect to each Plan is:

**Medical Reimbursement Plan** - Your maximum annual contribution is \$4,998.

**Dependent Care Assistance Plan** - There are limitations to the amount you can contribute each year:

--The maximum annual contribution is \$4,998; however:

- (i) If you file your federal income tax return as "married, filing separately," your maximum annual contribution is \$2,499; or
- (ii) If your annual earned income or your spouse's annual earned income is less than \$4,998, the lowest income amount is the most you can contribute.

In determining your spouse's income:

- If your spouse is "Disabled" (not physically or mentally able to care for himself or herself) and you have no other qualifying dependents, your spouse will be considered to have earned \$250 each month your spouse is Disabled.
- If your spouse is Disabled and you have one or more qualifying dependents other than your spouse, your spouse will be considered to have earned \$500 each month your spouse is Disabled.
- If your spouse is a full-time student and you have one qualifying dependent, your spouse will be considered to have earned \$250 each month your spouse is a full-time student.
- If your spouse is a full-time student and you have more than one qualifying dependent, your spouse will be considered to have earned \$500 each month your spouse is a full-time student.

**Q.12 Can you change the amount of your salary redirection contribution during the year?**

Once you have made your election for the year, that election will stay in effect for the entire year. You can only change your election:

- (1) If you have a "qualified change in family status" and you notify the Benefits and Risk Management Department within 60 days of such change:

A qualified change in family status includes a change in your:

- Marital Status - including your marriage, the death of your spouse, your divorce, legal separation, or an annulment;
- Number of dependents - including birth, adoption, placement for adoption, or death of your dependent, or an event that causes your dependent to satisfy or cease to satisfy the requirements for

coverage due to attainment of age, student status, or any similar circumstance;

- Employment status - including a termination or commencement of employment by you, your spouse or your dependent;
- Work schedule - including a reduction or increase in the hours of employment by you, your spouse, or your dependent, including a switch between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence; or
- Any other change in family status permitted under Section 125 of the Code and the applicable regulations thereunder.

If the change in family status results in you, your spouse, or your dependent gaining or losing eligibility under this plan, or a plan of your spouse or your dependent, the change in election must be consistent with this change.

- (2) If you (or your spouse or dependent) become entitled to coverage under Medicare or Medicaid, you may revoke or reduce your election for benefits under the Medical Plan. In addition, if you or your spouse or dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, you may elect to begin or increase coverage for you or your spouse or dependent (as applicable) under the Medical Plan.
- (3) If the Administrator receives a qualified medical child support order from a court or administrative agency that requires accident or health coverage for your child, you or the Administrator may change your election to provide coverage for the child. Likewise, you may change your election under this Plan to cancel an election for the child if the qualified medical child support order requires your former spouse to provide such coverage for the child.
- (4) If you qualify for special enrollment under the Medical Plan, you may revoke an election related to accident or health coverage and make a new election that corresponds with such special enrollment rights.
- (5) If you take a leave under the Family and Medical Leave Act, you may revoke your election for the remainder of the plan year with respect to group health benefits.
- (6) If the cost of a District-sponsored Plan (other than the Medical Reimbursement Plan) increases or decreases during the Plan Year (other than a cost change under the Dependent Care Assistance Plan that is imposed by a dependent care service provider who is your relative), an automatic corresponding change will be made to your election. If the cost increase is significant, the Administrator may allow you to (i) make a corresponding change in your election or (ii) revoke your election for the remainder of the Plan Year and elect similar coverage under another District-sponsored Plan for the remainder of the Plan Year.

- (7) In the event that coverage under a District-sponsored Plan (other than the Medical Reimbursement Plan) is significantly reduced or terminates during a Plan Year, the Administrator may allow you to revoke your election for that coverage for the remainder of the Plan Year and elect similar coverage under another District-sponsored Plan for the remainder of the Plan Year. If a new District-sponsored Plan providing coverage similar to one or more existing District-sponsored Plans is added during a Plan Year, the Administrator may allow you to elect the new optional benefit on a prospective basis and to make a corresponding change in your election. If you elect coverage under a District-sponsored Plan (other than the Medical Reimbursement Plan) and the plan is terminated during the Plan Year, the Administrator may allow you to elect another optional benefit on a prospective basis and to make a corresponding change in your election.
- (8) You may revoke an election for the remainder of a Plan Year and file a new election on account of and corresponding with a change made under an employer-sponsored plan of your dependent or spouse if the other plan allows your dependent or spouse to make an election change that would be permitted under paragraphs (1) – (7) above or if the period of coverage under the Plan is different from the period of coverage under the other plan.

If you are permitted to change your election under the Medical Reimbursement Plan, you may not reduce your annual election to an amount less than the dollar amount of any reimbursable expenses incurred during the portion of the year ending prior to the date of your change of election. If you change your election and then subsequently submit expenses (whether incurred before or after the change) in excess of your changed election, the excess expenses will not be eligible for reimbursement under the Medical Reimbursement Plan.

**Q.13 What happens if the District-sponsored Plan’s premiums change?**

Your salary redirection will be automatically changed in the amount of any premium change during the year.

**Q.14 Does the District make contributions to the Plan?**

To the extent your salary or wages are redirected to provide non-cash benefits through the Plan, these reduced amounts become District contributions to the Plan.

**IV. Plan Benefits**

**Q.15 What benefits are provided in the Plan?**

The Plan provides that you may set aside a portion of your pay from the District through the Plan to pay for your share of the premiums under the District-sponsored Plans, and also to make contributions to the Medical Reimbursement Plan and to the Dependent Care Assistance Plan. As described above, any required contributions for a pay period that exceed your compensation for that pay period (as reduced to account for any District required reserve and any other legally required or higher priority deductions) must be paid by you on an after-tax basis.

**Q.16 What benefits are provided in the Pre-Tax Premium Plan?**

The Pre-Tax Premium Plan provides for payment of your share of the premium cost of the District-sponsored Plans. The benefits provided in the District-sponsored Plans are described in detail in the Plano Independent School District Employee Health Benefit Plan document. Please contact the Benefits and Risk Management Department if you have questions concerning any of the District-sponsored Plans.

**Q.17 What benefits are provided in the Medical Reimbursement Plan?**

The amount you have elected on your enrollment election form to be applied to your Medical Reimbursement account will be used to reimburse you for eligible medical expenses. Protected health information will not be used or disclosed by the Medical Reimbursement Plan except as permitted by the privacy rules under the Health Insurance Portability and Accountability Act. See the official Plan document and the Employee Health Benefit Plan document for more information regarding the privacy rules.

**Eligible Medical Expenses.** Eligible medical expenses are those expenses which are otherwise deductible on your federal income tax return (without regard to the percentage of adjusted gross income limitation) under Section 213 of the Code. However, eligible medical expenses do not include an expense incurred for premiums paid for health coverage under a plan maintained by an employer of your spouse or dependent. In addition, eligible medical expenses include expenses for certain non-prescription drugs taken for medical care, even though the expenses of such drugs are not otherwise deductible on your federal income tax return.

You are encouraged to consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses" for further guidance as to what is or is not an eligible medical expense if you have any doubts.

There are limitations on eligible expenses, including that:

- They must be expenses which are not paid or reimbursed through another benefit plan or from any other source;
- Expenses must be incurred by you, your spouse, or your dependent (who qualifies as a dependent on your Federal income tax return, except that the rules denying dependent status to married individuals filing joint returns and qualifying relatives who have income exceeding the exemption amount do not apply);
- Expenses must be incurred during the year for which your election is made (expenses are treated as having been incurred on the date the services are provided);
- Expenses must be incurred while you are a Participant in the Medical Reimbursement Plan; and
- You cannot deduct reimbursed expenses from your income taxes.

**Q.18 What benefits are provided in the Dependent Care Assistance Plan?**

The amount you have elected on your enrollment election form to be applied to your Dependent Care Assistance account will be used to reimburse you for eligible dependent care expenses under the Dependent Care Assistance Plan.

Eligible dependent care expenses are those expenses that would be considered "employment-related expenses" under Section 21(b)(2) of the Code (relating to expenses for household services and for the care of a qualifying dependent which are necessary for gainful employment) if paid for by you. You are encouraged to consult your personal tax advisor or IRS Publication 503, "Child and Dependent Care Expenses" for further guidance as to what is and what is not an eligible dependent care expense.

There are limitations on eligible dependent care expenses, including that:

- (a) Expenses must be incurred for household services or for the care of one or more members of your home who are "Qualifying Dependents." A Qualifying Dependent is:
  - (i) Your "qualifying child" under age thirteen (13) with respect to whom you are entitled to an exemption on your Federal income tax return;
  - (ii) Your dependent (who qualifies as a dependent on your Federal income tax return) who is physically or mentally incapable of caring for himself or herself and who resides with you in your principal residence for more than one-half of the year;
  - (iii) Your spouse who is physically or mentally incapable of caring for himself or herself and who resides with you in your principal residence for more than one-half of the year;
- (b) They must be expenses which are not paid or reimbursed through another benefit plan or from any other source;
- (c) Expenses must be incurred during the year for which your election is made (expenses are treated as incurred on the date the services are provided);
- (d) Expenses must be incurred while you are participating in the Dependent Care Assistance Plan;
- (e) The total amount of reimbursements made in a taxable year, under this and any other dependent care plan, cannot exceed your earned income (or if you are married, the lesser of your earned income, or your spouse's earned income), during that taxable year;
- (f) The expenses are necessary to enable you and your spouse (if married) to be gainfully employed;
- (g) Your spouse must work outside the home, be a full-time student or be physically or mentally incapable to care for himself or herself;
- (h) If services were provided outside your home, such services must be incurred for the care of a Qualifying Dependent who is your qualifying child under the age of 13, or for any other Qualifying Dependent who regularly spends at least eight hours a day in your household;

- (i) Services rendered in a Dependent Care Center as defined in Section 21(b)(2)(D) of the Code must satisfy the requirements of Section 21(b) of the Code and the regulations issued thereunder;
- (j) The person providing the service to your Qualifying Dependent cannot be (i) an individual with respect to whom a deduction is allowable under Section 151(c) of the Code to you or your spouse; (ii) your spouse; or (iii) your child who is under 19 years of age at the end of the year in which the service is provided;
- (k) You will not take a tax credit on your income tax return for the expenses which are reimbursed under the Dependent Care Assistance Plan; and
- (l) No Dependent Care Assistance Plan benefit will be provided to "Highly Compensated Employees" within the meaning of Section 414(q) of the Code, to the extent that the average of benefits provided under the Dependent Care Assistance Plan to employees who are not Highly Compensated Employees would be less than 55% of the average of Dependent Care Assistance Plan benefits provided to Highly Compensated Employees.

**Q.19 What happens if money is left in your Medical Reimbursement or Dependent Care Assistance account at the end of a year?**

You will forfeit any balance remaining in your accounts at the end of a year. You cannot carry over any outstanding balance from one year to the next year, and any outstanding balance becomes the property of the District. Hence, it is important for you to consider carefully how much of your salary or wages you desire to allocate to your Medical Reimbursement or Dependent Care Assistance account during a year.

**V. Reimbursement Procedures**

A "Flex Debit Card" is available for paying certain eligible expenses under the Medical Reimbursement and Dependent Care Assistance accounts. Reimbursement procedures for the Flex Debit Card are described in Part VI below. You must use the reimbursement procedures described in Questions 20 through 22 for all eligible expenses other than those paid using the Flex Debit Card procedures described in Part VI below.

**Q.20 What do you need to do to obtain reimbursement from your Medical Reimbursement or Dependent Care Assistance account?**

When you have expenses during the year that are eligible for reimbursement, you must complete an expense reimbursement request form and submit it to the address shown on the form. You will be required to provide information verifying that you have incurred the eligible expense, such as a statement or a receipt. Distributions from your accounts to pay for an eligible health or dependent care expense will only be made for services that have already been performed, even though you may have previously paid the provider for such services. In other words, no prepaid expenses can be reimbursed before the date the services have been performed.

For the Medical Reimbursement Plan, reimbursement requests will be paid up to the amount of your annual election. For the Dependent Care Assistance Plan, if the balance

in your account is enough to reimburse the entire expense, you will receive a check for the full amount. If the expenses are for more than your balance, the remaining amount of your reimbursement request will be carried over to the next period and will be paid once new contributions are made to your account to cover the balance.

**Note:** Neither the District nor the Plan Administrator makes any commitment or guarantee that any amounts reimbursed to or for you will be excludable from your gross income for federal or state income tax purposes. It is your obligation to determine whether each reimbursement is excludable from your gross income, and to notify the Plan Administrator if you have reason to believe that any such reimbursement is not so excludable.

**Q.21 What type of documentation must be submitted to obtain payment from your Medical Reimbursement or Dependent Care Assistance account?**

- If you have an eligible medical expense, you must submit a statement from the service provider showing the name and address of the service provider, the date services were performed, type of service(s), and amount(s) charged.
- If the eligible medical expense is covered by any of the District-sponsored Plans or by any other medical or dental plan, you should file a claim first with that plan. The amount not paid by that plan is the amount you can claim for reimbursement. The explanation of benefits form you receive from that plan after filing a claim details what is covered and what that plan pays. You may submit this explanation of benefits form as part of your medical expense reimbursement claim.
- If you have an eligible dependent care expense, you must submit either a statement from the service provider or from yourself which shows the name and address of the service provider, the dates on which services were provided, the location at which services were provided, the Taxpayer Identification Number of the service provider (or, if an individual, the individual's Social Security Number) and the amount charged.
- Remember, you cannot claim reimbursement for services provided by an individual that you claim as a dependent on your federal income tax return or, with respect to the Dependent Care Assistance Plan, your child who is under age 19 as of the end of the year.

If you do not file the appropriate form for reimbursement, or fail to provide the information required to verify that the expense is eligible for reimbursement, payments to you could be delayed or denied.

**Q.22 When is the last day you can submit a request for reimbursement?**

Any eligible expenses that you incur during the year can be submitted for reimbursement at any time during that year. To give you time to file for expenses incurred during the last few months of a year, you can file for reimbursement during the first four months of the following year (i.e., by April 30th). However, if your contributions cease, you have 90 days to submit a request for reimbursement.

See Question 23 titled "When do your contributions cease?" for further details regarding the payment of claims.

It is important to remember that any amounts contributed to either account that are not paid to you as reimbursements will be forfeited. Also, expenses reimbursed from these accounts cannot be reimbursed under any other benefit plan or claimed as an income tax deduction or tax credit.

## **VI. Flex Debit Card**

### **General Information**

The District and the Plan Administrator have arranged with Med-I-Bank, Inc., for the issuance of debit-like, stored value cards to employees enrolled in a Medical Reimbursement flexible spending account. The purpose of the card is to provide Participants with an added convenience for payment of certain eligible expenses under the flexible spending accounts. The Plan will advance funds on the Participant's behalf to pay for card transactions, and will deduct the amount of this advance from the Participant's flexible spending account. All card transactions are subject to the terms and conditions of the Plan and the cardholder agreement and to any and all state and federal regulations.

The Plan reserves the right to deny a Participant's request for a card.

Use of the card is optional. Participants may continue to submit manual claims according to the procedures described in Questions 20 through 22 in the previous section.

### **Participant's Responsibilities**

Use of the card does not affect your responsibilities and tax liabilities of enrolling in the Plan.

Each time the card is used, you agree to all terms and conditions of the Plan and the cardholder agreement, including proper use of the card.

You must acquire and retain sufficient documentation for all card transactions. The Plan Administrator will request documentation to substantiate payments, and you should retain documentation for your tax records.

You must report lost or stolen cards immediately.

### **Proper Use of the Card**

The card may only be used for eligible expenses under the flexible spending account(s) for which you have enrolled.

The card may only be used with participating providers.

### **Results of Non-Response or Improper Use**

If you receive a request from the Plan Administrator for documentation or additional information to substantiate a card transaction, you must provide that documentation within the time limits established by the Plan Administrator.

Your card may be suspended or revoked if documentation or additional information is not provided in a timely manner. If documentation is not provided, the Plan may determine that the transaction is ineligible (non-qualified), and the procedure below may be followed.

If you use the card improperly (e.g. for an ineligible expense), you must repay the amount to the Plan within the time limits established by the Plan Administrator. Your card may be suspended or revoked if amounts are not repaid in a timely manner. The Plan reserves the right to adjust your account balance, withhold from future payments, withhold from your paycheck, or adjust your W-2, for any ineligible or non-qualified amounts not repaid to your Plan account in a timely manner.

Your card may be suspended or revoked for any violations of the Plan or cardholder agreement.

### **Example of Improper Use**

At the doctor's office or pharmacy, a Participant uses the card to pay the entire cost. The claim is submitted under the Participant's medical plan resulting in payment by the medical plan at a PPO network negotiated discount. The Participant must immediately repay to his/her flexible spending account the amount of the payment by the medical plan and the PPO network negotiated discount, as these are ineligible expenses under the Medical Reimbursement spending account.

## **VII. Termination of Election and Contributions**

### **Q.23 When do your contributions cease?**

Your participation in the Medical Reimbursement Plan and Dependent Care Assistance Plan, as well as the payment of your District-sponsored Plan's premiums via payroll reduction will cease on the earlier of the last day of the payroll period in which you receive compensation, or the last day of the payroll period in which you cease to be an eligible employee due to:

- your termination of employment (voluntary or involuntary), retirement or death;
- your absence from work for any reason if your pay stops (unless you are taking a leave of absence or are a food service or transportation division Employee on summer break as described below); or
- your reduction in hours worked below the minimum required to participate.
- your failure to make required contributions.

Contributions will also stop at the end of each year.

You may, however, elect to continue making contributions to the plan on an after-tax basis if you terminate employment and elect to continue health plan coverage. You may also elect to continue coverage under the plan by making after-tax contributions if you are taking an unpaid leave of absence or if you are on a Family and Medical Leave Act (FMLA) leave.

If you are a food service or transportation division employee and are a Participant immediately prior to the start of summer break, your participation in the Medical Reimbursement Plan and Dependent Care Assistance Plan will continue during the summer break (until August 31), and contributions with respect to that period will be deducted from your compensation over the other pay periods during the year. However, if you terminate employment before the end of the year, you will be billed on an after-tax basis for any required contributions for periods of coverage prior to your termination, and

your participation will be retroactively terminated if you fail to pay any required contribution. See Q&A-2 for additional information.

**Q.24 How are your accounts affected after you cease participation?**

You will be allowed to submit claims for eligible expenses incurred before you cease participation. Any expenses incurred after you cease participation are not eligible for reimbursement. You will have 90 days from the date you cease participation to submit claims.

**Q.25 Can you change the amount of your salary redirection contribution if you terminate employment and are rehired in the same plan year?**

- (1) With respect to an election that is **not** related to an accident or health plan, you may not make a new benefit election within the same plan year in which you terminate employment and revoke your existing benefit elections;
- (2) With respect to an election that is related to an accident or health plan, you may have such election automatically reinstated if you resume employment within 30 days of your termination of employment, unless there has been another intervening event that would permit a change in election.
- (3) If you revoke your election related to group health benefits after taking a FMLA leave, you may reinstate your former election unless you would receive greater benefits than a participant who has not taken leave during the plan year.

**Q.26 What will happen if you do not return the enrollment election form?**

Your District-sponsored Plan's premiums will automatically be deducted from your pay on a pre-tax basis (subject to the rules described in this booklet for pay periods during which your contributions exceed your adjusted pay) unless you complete and return the enrollment election form declining coverage, as previously mentioned. If you do not return a completed enrollment election form for the Medical Reimbursement Plan and/or Dependent Care Assistance Plan during the annual enrollment election period, your election for the year will be deemed to be zero and no amounts will be deducted from your pay during the next year to fund these Plan accounts. You will then have to wait until the next annual enrollment election period unless you have a change in status as previously described.

**Q.27 What should you do if you believe you are entitled to payment of benefits under the Plan which have not been paid?**

If you believe you are entitled to benefits under the Plan that you have not received, you should file a claim with the Plan Administrator stating why you think you are entitled to the benefits you are claiming under the Plan. Your claim must be in writing and delivered to the Plan Administrator in person or by mail, postage prepaid. Within 90 days after receipt of a claim, you will receive a written decision on your claim from the Plan Administrator. If your claim is wholly or partially denied, the Plan Administrator's

decision will specifically explain why, and whether you can make the claim acceptable. If your claim is wholly or partially denied, you will have 60 days to file a written appeal of the denial with the Plan Administrator. You have the right to review the applicable plan in connection with your appeal and to request a hearing with the Plan Administrator. A written decision on your appeal must be made by the Plan Administrator within 60 days, unless you have requested a hearing or other special circumstances requiring an extension of time; the decision must then be made within 120 days. The decision will contain specific reasons for its conclusions.

**Q.28 How does COBRA apply to the Plan?**

The COBRA continuation rules apply to the Medical Reimbursement Account portion of the Plan. You may elect to receive COBRA continuation coverage under such portion of the Plan for the remainder of the year if you would otherwise lose coverage as the result of a qualifying event. See the “Continuation of Coverage” section of the Plan document for the District’s Employee Health Benefit Plan for a description of the rules regarding when you are eligible for COBRA coverage, how to elect COBRA coverage, and when COBRA coverage terminates.

Please note that for most participants, there is no tax or other benefit to electing continuation coverage under the Medical Reimbursement Plan. The Medical Reimbursement Account allows you to reimburse yourself of a pre-tax basis for qualifying medical expenses. However, if you elect COBRA continuation coverage, you will be required to contribute on an after-tax basis the amount you previously elected to contribute to such Account. The tax benefit of the Medical Reimbursement Plan is lost when you make contributions on an after-tax basis. In addition, the cost of COBRA continuation coverage is 102% of the ordinary cost of coverage under the Plan. Thus, if you continue coverage under COBRA, you are only eligible to receive reimbursements of \$100 for every \$102 you contribute to your Medical Reimbursement Account.

Continuing COBRA coverage under the Medical Reimbursement Plan is advantageous only if you have a significant unused Medical Reimbursement Account balance. In that case, continuing coverage will enable you to continue to incur eligible medical expenses and to receive reimbursements from your Account, up to the amount you elected to contribute during the period of coverage. As described above, however, you must continue to make contributions (on an after-tax basis) to your Account during the period COBRA coverage is continued. If you stop making contributions, your COBRA continuation coverage will terminate and you will forfeit any unused Medical Reimbursement Account balance.

**VIII. Miscellaneous**

**Q.29 May you assign your benefits which are payable under the Plan?**

No. You cannot assign, pledge, encumber or otherwise alienate benefits which are payable or become payable under the Plan prior to your receipt of those benefits.

**Q.30 May you still be discharged if you are a participant in the Plan?**

Yes. Neither the establishment of the Plan, nor your participation, is deemed to constitute a contract of employment. Every employee, whether or not a Participant, will remain subject to discharge, just as though the Plan had never been adopted.

**Q.31 How long will the Plan be in effect?**

The District has established the Plan with the intent that it will be maintained for an indefinite period of time. The District intends that the terms of the Plan, and each employee's rights thereunder, including those related to coverage and benefits, will be legally enforceable and that the Plan will be maintained for the exclusive benefit of its employees. The right to alter, amend, suspend or terminate the Plan is reserved to the District and it may do so at any time. If the Plan is terminated, all enrollment elections with respect to the Plan will terminate.

**Q.32 How is the Plan administered?**

The Plan is supervised by a Plan Administrator, which is appointed by the District. The Plan Administrator has the overall responsibility for administering the Plan, including interpreting the terms and provisions of the Plan and deciding all actions concerning the Plan and the eligibility of any person to participate in the Plan, approving reimbursement requests and authorizing payment of benefits.

**Q.33 Does the District make contributions to the Plan?**

No. However, to the extent your salary or wages are redirected to provide non-cash benefits through the Plan, these reduced amounts become District contributions to the Plan.

**Q.34 Who pays the cost to administer the Plan?**

Plan administration will be provided by an outside vendor independent of the District. Costs for Plan administration will be paid by the District.

**Q.35 Can the Plan Administrator or the District change the amount of your salary redirection contribution during the year?**

Yes. The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or benefits, and to comply in this respect with the requirements of the Code and the regulations issued thereunder. If, in the judgment of the Plan Administrator, the operation of the Plan in any year would result in such discrimination, then the Plan Administrator will select and exclude from coverage under the Plan certain Participants and/or reduce Plan contributions and/or benefits under the Plan in a uniform and non-discretionary manner in order to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

**Q.36 What “choice of law” will be used to interpret and enforce the Plan?**

The Plan will be construed and enforced according to the laws of the State of Texas to the extent that those laws have not been superseded by federal law.