WATERTOWN SCHOOL DISTRICT NO. 14-4

Flexible Benefit Plan

Summary Plan Description

Amended and Restated July 1, 2006

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SUMMARY PLAN DESCRIPTION

Introduction

Watertown School District No. 14-4 has developed and added an innovative plan to the employee benefit program which we call "Flexible Benefit", a flexible benefit plan. As the name implies, employees who participate in the Plan have a great deal of flexibility in choosing the type of benefits they have.

Here's an example of how one of the available benefits could work for you. Although your group medical plan provides excellent comprehensive benefits, there are often some charges for medical care which are not reimbursed by your plan or other insurance coverage. These out-of-pocket expenses may be your deductible, copayment or amounts for services not covered by your plan.

Such common expenses are considered by the Internal Revenue Service to be tax deductible. With Flexible Benefit, you may be able to take advantage of this tax deduction before you file your income tax return and for the entire amount of the expense.

You are able to do this by directing, in advance, that a part of your salary is to cover these medical expenses. As a result, you do not pay income tax or Social Security tax on these dollars. These dollars are considered to be pretax dollars which you are placing in an account to be used to purchase medical benefits.

This Plan is only useful, however, for qualified expenses which can be predicted. Keep in mind, that most unforeseen and unplanned expenses (such as emergency surgery or accidental injuries) are reimbursed partially or wholly by your group medical plan.

This Summary Plan Description is intended to cover the most important features of the Plan and is subject to the detailed provisions of the Plan documents. We ask that you read it thoroughly and retain it along with your other employee benefit plan information, legal documents, and private insurance policies.

Eligibility

Administrative or Salaried Certified Teachers, and Classified employees are eligible provided they work a minimum of 7 hours per day for 177 days or a minimum of 1,239 hours annually.

Benefit Choices

In this Plan, you may choose from a variety of benefits which are grouped into three separate categories called Flexible Benefit Accounts:

(1) Employer-Sponsored Benefit Coverage Costs:

- Medical Coverage
- Group Term Life Coverage

A description of each of these benefits is provided in separate Summary Plan Descriptions. Please refer to them for details on coverage and eligibility.

(2) Medical Care Expense Reimbursements:

- Expenses not covered or paid for by insurance
- Vision and hearing care
- Any medical (or dental) expense considered as deductible by the IRS under Section 213
- Over-the counter medicine and pain relievers for a medical condition without a physician's prescription for medical care. This does not include such things as: dietary supplements, vitamins, toiletries, cosmetics and sundry items
- Do not include any individual medical insurance premiums nor after-tax premiums paid to your spouse's employer

(3) Dependent Care Expense Reimbursements:

- Must be employment-related expense which permits employee and spouse to work
- Must be considered an expense for which you would be entitled to take a tax credit by the IRS under Section 21

Contributions

The Plan will be funded with dollars, called Benefit Dollars, contributed by you. Watertown School District will establish up to 3 separate Flexible Benefit Accounts for each employee. One account is for your costs of the group benefit coverages you have selected; one for qualifying medical expenses, and one is for qualifying dependent care expenses.

At enrollment time, you may voluntarily elect to direct a part of your salary each pay period to the appropriate account up to the following maximums and minimums:

- Benefit Coverages: No maximum or minimum;
- Medical Care Expenses: $5,000 maximum per Plan Year; and

- Dependent Care Expenses: The annual maximum is the lesser of your earned income or, if married, your spouse's earned income, $5,000 or $2,500 if married and filing separate tax returns.

If there is a change in the cost of the type of group benefit coverage you selected during a Plan Year, the District may automatically make the necessary adjustment.

Tax laws and Social Security Administration guidelines change from time to time. If such a change occurs affecting your election, Watertown School District will make any necessary payroll adjustment.

Once you allocate your Benefit Dollars to Benefit Coverages, Medical Care Expenses and Dependent Care Expenses, they cannot be used for any other purpose.

Enrollment/Election

The Plan Year is from October 1 through September 30 of each year. You elect to participate in the Plan prior to the beginning of the Plan Year or prior to the date on which you first become eligible to enter the Plan, whichever first occurs.

Enrollment for participation in the Benefit Coverage category is automatic if you are enrolled in the coverages listed. If you do not want to pay for these coverages with tax-free money, you must complete a waiver form.

Enrollment consists of:

- Completing an irrevocable Agreement form;

- Completing additional enrollment forms, if any, required for the benefit coverages.

Prior to the beginning of each Plan Year, you will have to do some financial planning to determine how many dollars you will need in each of the Flex accounts for the entire Plan Year. An Enrollment Kit will be provided which contains information to help you with the necessary planning. You will be given the opportunity to review your decisions once each year.

Changing Your Election

You cannot change your election to participate in the Plan or vary the salary reduction amounts you have selected during the Plan Year.

There are several important exceptions to this general rule: You may change or revoke your previous election only as described below.

1. **Change in Status:** If one or more of the following Changes in Status occurs, you may revoke your old election and make a new election, provided that both the revocation and new election are caused by and are consistent with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below and any other events that the Plan Administrator (in its sole discretion) determines to be within prevailing IRS guidance:

   - a change in your legal marital status (such as marriage, death of your spouse, divorce, legal separation or annulment);

   - a change in the number of your tax dependents (as defined in Code Section 152) (such as birth or adoption of a child, placement for adoption or the death of a dependent);

   - a change in employment status by you, your spouse, or your dependent that affects the benefit eligibility under a cafeteria plan or other employee benefit plan of the employer of you, your spouse, or your dependents (such as 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 or union to nonunion or vice versa, incurring a reduction or increase in hours of employment (e.g., going from part-time to full-time), or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

   - your dependent's satisfying or ceasing to satisfy the dependent eligibility requirement for a particular benefit; (such as attaining a specified age, getting married, or ceasing to be a student) and

   - a change in your, your spouse's or your dependent's place of residence. (For example, moving in/out of an HMO territory that affects eligibility.)

   If a Change in Status occurs, you must inform the Plan Administrator and complete a new election form within 30 days of the occurrence.

   A Participant may change or terminate his or her election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent (referred to as the general consistency requirement.) The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on that change.

a. *Loss of Dependent Eligibility:* For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverages, a Participant may only elect to cancel accident or health insurance coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant's Spouse (not ex-spouse) or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, the Participant may increase his election to pay for such coverage.

b. *Gain of Coverage Eligibility Under Another Employer's Plan:* For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under this Employer's plan or another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other employer's plan.

c. *Dependent Care Expense Reimbursement Benefits:* With respect to the Dependent Care Expense Reimbursement benefit plans, a Participant may change or terminate his or her election only if (i) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the election change is on account of and corresponds with a Change in Status that affects eligibility of dependent care expenses for the tax exclusion available under Code § 129.

d. *Group Term Ljfe Insurance, Accidental Death & Dismemberment, and Disability Income Coverage:* For any Change in Status involving a Participant's legal marital status or the employment status of a Participant's Spouse or Dependent (disregarding the requirement that the event cause a loss or gain of eligibility), a Participant may elect either to increase or to decrease group term life insurance or disability income coverage offered under the Plan.

2. **HIPAA Special Enrollment Rights:** If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in medical coverage for yourself or for your eligible dependents because of outside medical coverage, and if eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), then you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly-acquired dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments and Orders:** If a judgment, decree or order from a divorce, legal separation, annulment or legal custody change (including a qualified medical child support order) requires your child to be covered under this Plan you may change your election to provide coverage for the child. If the order requires that your former spouse cover the child, you may change your election to revoke coverage for the child provided other coverage is actually procured.

4. **Entitlement to Medicare or Medicaid:** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Furthermore, if you, your Spouse, or a Dependent loses eligibility for such coverage, you may elect to commence or increase that person's accident or health coverage.

5. **Changes in Cost: (These rules do not apply to health care flexible spending accounts.)**

    a. *Automatic Increase or Decrease for Insignificant Cost Changes:* If the cost of a Benefit Plan or Policy increases or decreases during a Plan Year by an insignificant amount, then the Pretax Contributions or After-tax Contributions (as applicable) under each affected Participant's election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in affected employees' elective contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

    b. *Significant Cost Increases/Decreases:* If the Plan Administrator determines that the cost of a Participant's Benefit Plan(s) or Policy(ies) significantly increases during a Plan Year, the Participant may either make a corresponding prospective increase in his or her contributions, or revoke his or her election, and in lieu thereof, receive coverage under another Plan option which provides similar coverage. If the Plan Administrator determines that the cost of a Participant's benefit plan(s) significantly decreases during a Plan Year, the participant may revoke his or her election, and in lieu thereof, receive coverage under the decreased Plan option which provides similar coverage. In the event of a decrease, Participants who were not previously enrolled could elect the decreased Plan option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

    c. *Limitation on Change in Cost Provisions for Dependent Care Expense Reimbursement:* The above "Change in Cost" provisions apply to Dependent Care Expense Reimbursement *only* if the cost change is imposed by a dependent care provider who is not a "relative" of the employee by blood or marriage (as that term is defined in Proposed Treas. Reg. §1.125-4(f)(2)(iii) or other IRS guidance).

6. **Changes in Coverage:** (These rules do not apply to health care flexible spending accounts.)

   a. *Significant Curtailment:* If the Plan Administrator determines that a Participant Benefit Plan or Policy coverage under this Plan is significantly curtailed or ceases during a Plan Year, the Participant may revoke his or her election under the Plan. In that case, each affected Participant may prospectively elect coverage under another Benefit Plan or Policy option which provides similar coverage but cannot drop coverage. If the Plan Administrator determines that a Participant Benefit Plan or Policy coverage under this Plan is significantly curtailed that results in a loss of coverage, the Participant may elect coverage under another Benefit Plan or Policy option which provides similar coverage, or can drop coverage if no other similar option is available. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a substitute Benefit Plan or Policy constitutes "similar coverage" based upon all the surrounding facts and circumstances.

   b. *Addition or Elimination of Benefit Package Option Providing Similar Coverage:* If during a Plan Year the Plan adds or eliminates a Benefit Plan or Policy, an affected Participant may elect a newly-added option or elect another Benefit Plan or Policy (where a Plan option has been eliminated), and may do so prospectively on a pretax basis by making corresponding election changes with respect to coverage under another Benefit Plan or Policy option that provides similar coverage. In the event of a significant improvement in a benefit plan, the Participant may revoke their current election and elect the improved benefit plan, and those Participants who previously waived coverage could elect to participate in the improved benefit plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a substitute Benefit Plan or Policy constitutes "similar coverage" based upon all the surrounding facts and circumstances.

   c. *Change in Coverage of Spouse or Dependent Under Their Employer's Plan:* A Participant may make a prospective election change that is on account of and corresponds with a change made under any employer plan (including the plan or the Spouse's, former Spouse's, or Dependent's employer), so long as (a) the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its participants to make an election change that would be permitted under IRS regulations; or (b) the Plan permits Participants to make an election for a Plan Year period of coverage which is different from the plan year period of coverage under the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's or Dependent's employer. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change in on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer.

Additionally, 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 Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law and adjustments may also be made to reflect insignificant mid-year premium increases imposed by third party insurers.

A Participant entitled to make a new election under this Section must do so within 30 days of the event. An Employee who is eligible to elect benefits and declined to do so during the initial election period or during a subsequent open enrollment period, may file a pretax contribution election change within thirty days of the occurrence of an event described in this section, but only if the election under the new salary reduction agreement is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to 30 days. All other new elections shall be effective prospectively immediately following the date the Participant files his new salary reduction agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

Prior to the beginning of each new Plan Year, you will be asked to review your Agreement form. At that time, you may make any change you wish to make. If you do not complete a new Agreement form, the existing Agreement with regard to the Medical Care Expense and/or Dependent Care Expense Reimbursement Account will not automatically renewed, and your participation in those accounts will cease for the new Plan Year.

Participation in this Plan with regard to the Benefit Coverages will continue from year-to-year unless you complete a Waiver form prior to the beginning of the new Plan Year or upon a change in family status.

Forfeitures

The Internal Revenue Service requires that you use all of your Benefit Dollars during the Plan Year or the Claims Extension Period or those Dollars are forfeited. Watertown School District cannot refund any dollars left in your accounts directly to you. The District may use such funds to offset losses experienced by the Employer and the administrative costs of the Plan.

Watertown School District wants to minimize the amounts forfeited by participants as much as possible. You are, therefore, encouraged to plan your elections carefully.

Other Pay-Related Benefits

Benefits under other Employer-sponsored plans, such as life, disability or retirement plans, will be based on your total compensation. Your total compensation will include any amounts you have contributed to the Flexible Benefit Plan.

Termination/Withdrawal From Plan

Should you decide to terminate from the Plan, you must submit a Waiver Form prior to the start of any Plan Year in which you do not wish to participate. The termination will be effective at the end of the current Plan Year.

Withdrawal from the Plan may be warranted because of a change in your family status. If so, you will need to submit a Revocation Form within 30 days of the status change.

Termination from the Company, Change in Employment Status, or Death

If you terminate employment, your participation in the Plan will end on the date such event occurs. You will still be entitled to reimbursement of dependent care expenses for the remainder of the Plan Year from Benefit Dollars remaining in your Flexible Benefit Account. However, upon termination, you are entitled to reimbursement of medical expenses only to the extent that the expenses are incurred during a month in which a contribution is made.

If you transfer to an ineligible classification, your participation in the Plan will end on the date such event occurs. You will still be entitled to reimbursement of eligible medical and dependent care expenses for the remainder of the Plan Year and the Claims Extension Period from Benefit Dollars remaining in your Flexible Benefit Accounts.

If you cease making contributions and are rehired within the same Plan Year, you can make a new election provided you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

In the event of your death, your named beneficiary will be given the same opportunity to use any Benefit Dollars in your account to pay any of your remaining eligible expenses or eligible expenses of your tax dependents that are incurred during a month in which a contribution is made.

Termination of Plan

Watertown School District fully intends to continue the Plan indefinitely, but reserves the right to amend or end it. If this Plan is terminated, District contributions and salary reductions will cease, but existing benefit elections will be satisfied.

Non-Discrimination

Benefits and contributions under this Plan will not discriminate in favor of highly compensated employees, and no more than 25% of the total benefits paid for under this Plan during any Plan Year may be paid to key employees. Watertown School District will advise participants if they will be affected by these provisions.

Benefit Coverage Claims

While the election to contribute to one or more of the benefit coverages may be made under this Plan, the benefits will be provided by and claims made under the underlying insurance contracts or plan documents. Contributions from your Benefit Coverages Account are used only to pay your portion of the cost of those benefits not to pay claims.

Qualifying Medical Care Expenses

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

1. The expenses are incurred for services rendered after the effective date of your election and during the Plan Year and the Claims Extension Period to which it applies. Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, and not when the Participant is formally billed or charged for, or pays for the medical care.

2. Each individual for whom you incur the expenses is:

    a. A dependent under age 19 or, if older, is a full-time student whom you are entitled to claim as a dependent on your federal income tax return.

    b. A spouse.

    c. Other tax dependent who is physically or mentally incapable of self-care.

3. The expenses must be for services incurred and already provided, not for services to be provided in the future.

4. The expenses must not be reimbursable by insurance or otherwise, and you cannot claim these same expenses as a deduction on your annual income tax return.

5. Medicine and drugs must be prescribed, (except for insulin).

6. Over-the-counter medicine and pain relievers for a medical condition without a physician's prescription for medical care. This does not include such things as: dietary supplements, vitamins, toiletries, cosmetics and sundry items.

7. Individual and spouse's group health care insurance premiums are <u>not</u> eligible expenses.

8. The expenses must qualify as a deductible expense by the Internal Revenue Service as stated in Section 213 and must also qualify under Section 125. Internal Revenue Service Publication 502 contains a listing of deductible health expenses.

Continuation Coverage

On April 7, 1986, a Federal law was enacted [Public Law 99-272, Title X] requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. [Both you and your spouse should take the time to read this notice carefully.]

If you are an employee covered by the Plan you have a right to choose this continuation coverage if you lose your group coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

NOTE: For health care flexible spending account plans, individuals will be eligible for Continuation Coverage only if they have a positive health care account balance at the time of a qualifying event described below (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if eligible for Continuation Coverage. If coverage is elected, it will be available only for the plan year in which the qualifying event occurs; such coverage for the health care account will cease at the end of the Plan Year or the Claims Extension Period and cannot be continued for the next Plan Year. Individuals will not be eligible for continuation coverage if they have a negative health care account balance at the time of a qualifying event (taking into account all claims submitted before the date of the qualifying event).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group coverage for any of the following four reasons:

1. The death of your spouse;

2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. Divorce or legal separation from your spouse; or

4. Your spouse becomes entitled to (that is, covered by) Medicare.

In case of a dependent child of a covered employee, he or she has the right to continuation coverage if group coverage is lost for any of the following five reasons:

1. The death of the employee;

2. The termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;

3. The employee's divorce or legal separation;

4. The employee becomes entitled to (that is, covered by) Medicare; or

5. The dependent ceases to be a "dependent child" as defined under the group plan.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the date of the event. The Employer has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health coverage will end.

If you choose continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment or within 60 days of the qualifying event. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Employer of the birth or adoption.

However, the law also provides that continuation coverage may be cut short for **any** of the following five reasons:

1. The Employer no longer provides group health coverage to any of its employees;

2. The premium for continuation coverage is not paid on time;

3. The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition he or she may have;

4. The qualified beneficiary becomes entitled to (that is, covered by) Medicare;

5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If you have any questions about the law, please contact your Employer. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify your Employer.

This "Continuation Coverage" notice is a summary of the law and is therefore general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance.

Coverage During Unpaid Leave Under Family and Medical Leave Act

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's health benefits on the same terms and conditions as though he were still an active Employee (i.e., the Employer will continue to pay its share of the premium to the extent the Employee opts to continue his coverage). If the Employee opts to continue his coverage, the Employee may pay his share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave), or the Employee may be given the option to pre-pay all or a portion of his share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his preleave compensation by making a special election to that effect prior to the date such compensation would normally be made available to him (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next plan year), or via other arrangements agreed upon between the Employee and the administrator (e.g., the administrator may fund coverage during the leave and withhold "catch-up" amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to reenter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

Qualifying Dependent Care Expenses

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

1. The expenses must be incurred to enable you to be gainfully employed. Gainful employment does not include unpaid volunteer work, or volunteer work for a nominal salary. The expenses are incurred for services rendered after the date of this election and during the Plan Year or the Claims Extension Period to which it applies. Expenses are treated as having been incurred when the Participant is provided with the dependent care that gives rise to the dependent care expenses, and not when the Participant is formally billed or charged for, or pays for the dependent care.

2. Each individual for whom you incur the expense is:

    a. A dependent of yours under the age of 13 when the care is provided and for whom you can claim an exemption.

    b. A spouse or other dependent of yours who is physically or mentally incapable of self-care and for whom you can claim an exemption.

3. Eligible expenses include:

    a. Service for the custodial care of the qualified dependent.

    b. Household services, such as housekeeper, maid or cook wages, provided they are related to the care of a qualified dependent.

    c. FICA and FUTA taxes on wages paid to a housekeeper.

    d. Extra expenses for providing lodging in your home to the housekeeper.

4. Ineligible expenses include:

    a. Out-of-home expenses for a dependent age 13 or over unless the dependent spends at least 8 hours each day in your home

    b. Transportation of a dependent to a day care center; transportation of care provider.

    c. Overnight camp expenses (not even the amount attributable to the day time cost).

    d. Education (Kindergarten or higher).

    e. Food, clothing, entertainment.

    f. Amounts you pay for dependent care while you are off work because of illness/injury, or because you are on vacation.

5. Eligible providers of child care include:

    a. A licensed day care center (a facility that provides care for more than 6 individuals not residing at the facility), only if the center complies with all applicable state and local laws and regulations.

    b. Any individual who is not a tax dependent of yours.

    c. Any child of yours age 19 or over who is not a tax dependent. (A child of yours who is under 19, regardless of whether he or she is a tax dependent, is <u>not</u> an eligible provider.)

6. You must report the correct name, address and taxpayer identification number of your dependent care provider. For individuals, the taxpayer identification number is the Social Security number or individual taxpayer identification number. If the provider is an organization, it is the employer identification number. You can use form W-10 to request the information from the care provider.

7. The expenses must be for services incurred and already provided, not for services to be provided in the future.

8. If you are married, both you and your spouse must be gainfully employed, unless your spouse is a full-time student or incapable of self-care.

9. Annual expense reimbursement may not exceed the lesser of:

    a. Your earned income (exclusive of salary reductions for any benefits);

    b. If married, your spouse's earned income;

    c. $5,000 ($2,500 if married, filing separate income tax returns).

    If your spouse is a full-time student or incapable of self-care, your spouse will be deemed to have earned income of $200 a month ($400 a month if you have 2 or more qualified dependents for which claims are filed).

10. The amount which you may consider in calculating the tax credit under the Federal Dependent Care Tax Credit is reduced, dollar-for-dollar, by any amount that you place into the Dependent Care Reimbursement Account.

11. A comparison of the Federal Tax Credit available on your personal tax return and your savings by using this Plan is necessary before you make your final decision regarding Dependent Care Expenses.

12. Amounts contributed to a Dependent Care Reimbursement Account will be shown on your W-2 statement, and must be reported on your personal tax return.

Filing Claims for Medical Care and Dependent Care Expenses

As you incur qualifying expenses, you must:

- First, submit the health care claim to the insurance company(s).

- Second, complete and submit the appropriate Claim Form with the following attached:

    - Itemized bills and/or

    - Explanation of Benefits form from the insurance company.

Reimbursement requests will be processed according to a schedule established by the Plan Administrator. However, the reimbursement will be processed no less frequently than monthly or when the total is at least a specified minimum amount (e.g. $50). All reimbursement requests must be in writing and in such form as may be established by the Plan Administrator. The form will contain a statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage.

Expenses incurred before you become a participant cannot be reimbursed, even if they are paid after you enroll. The entire amount of your annual contribution into the Medical Care Expense Account (reduced by any prior reimbursements) will be available to pay eligible expenses when they are claimed during the Plan Year or the Claims Extension Period.

Reimbursement claims will be accepted for a period of time, as determined by the Plan Administrator, following the end of the Claim Extension Period. At the end of the Claim Extension Period any existing claims remaining unreimbursed due to lack of funds in your account cannot be carried forward to the next Plan Year. Claims for Medical Care or Dependent Care Expenses must be submitted for payment under one or the other category, but not both. In addition, funds in one account cannot be used for other expenses.

Medical Care and Dependent Care Expenses which are reimbursed under this Plan will not be deductible on your personal income tax return.

Denial of Claims Review Procedure

If a claim is wholly or partially denied, the District will furnish to the Participant, within a reasonable time after receipt of proof of claim, written notice of the decision denying benefits. The notice will state the specific reason or reasons for the denial, and will make specific reference to pertinent plan provisions on which the denial is based. The Participant will be given a description of any additional material or information necessary for further consideration of the claim, and an explanation of why such additional information is necessary. The notice will also contain an explanation of the plan's claim review procedures. A Participant who receives this notice that a claim has been wholly or partially denied may ask for a review of the claim. This is to be done within 60 days after notice of the denial is received, and the Participant (or the Participant's authorized representative) should make written request for a review of this claim. The written request should then be submitted to the Plan Administrator (your Employer) at the address shown in this booklet.

Within 60 days after receipt of a request for review (or not later than 120 days in the event special circumstances require an extension), a written review decision by the District will be furnished to the Participant, setting out the specific reasons for the decision and the pertinent plan provisions on which the decision is based.

The procedures to be followed in presenting claims for benefits under the employer benefit plans will be found in each applicable Summary Plan Description.

PLAN DESCRIPTION AND PARTIES INVOLVED

Employer and Plan Sponsor	Watertown School District No. 14-4.
Employer Identification Number	46-6001273
Plan Number	505
Plan Administrator	Watertown School District No. 14-4
Agent for Service of Legal Process	Watertown School District No. 14-4 Service of legal process may also be made upon the Plan Administrator
Business Address for All of the Above	P.O. Box 730 Watertown, SD 57201-0730
Telephone	(605) 882-6314
Type of Plan	Cafeteria or Flexible Benefit Plan
Funding	Employee Contributions
Documents which Constitute the Plan	The Plan Document
Initial Effective Date of the Plan	January 15, 1990
Plan Year	October 1 through September 30 Records are kept on a Plan Year basis
Claims Extension Period	October 1 through December 15 beyond the end of the Plan Year
Claims Administrator	Watertown School District No. 14-4 P.O. Box 730 Watertown, SD 57201-0730 Phone: (605) 882-6314

This booklet contains only a brief description of the main features of the Watertown School District No. 14-4 Flexible Benefit Plan as amended and restated July 1, 2006.

The complete provisions of the plans are set forth in legal documents. If for any reason there is any omission in this booklet, or any other difference between this booklet and the plan documents, the plan documents will in all respects control and govern. Upon written request to Watertown School District, copies of all plan documents, descriptions, and reports required by the Employee Retirement Income Security Act of 1974 will be furnished. You will be charged for the reasonable costs of copying the materials requested. Any of these materials may be examined in our human resources office during regular business hours.