

**BOARD OF EDUCATION  
SAN DIEGO UNIFIED SCHOOL DISTRICT  
SAN DIEGO, CALIFORNIA**

**I.25.**  
1-27-15

Resolution in the Matter of Adopting the )  
American Fidelity Assurance Company (AFA) ) **RESOLUTION**  
Flexible Spending Account Plan )

WHEREAS, the undersigned Principal of San Diego Unified School District (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on January 27, 2015, and that such resolutions have not been modified or rescinded as of the date hereof:

NOW, THEREFORE, BE IT RESOLVED, that the form of amended Cafeteria Plan including a Dependent Care Flexible Spending Account and Health Flexible Spending Account effective January 1, 2015, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

BE IT FURTHER RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

BE IT FURTHER RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Cafeteria Plan by delivering to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to this meeting, which form is hereby approved; and

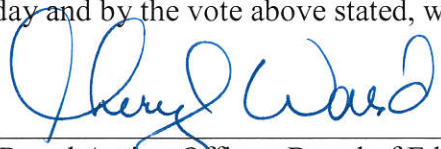
The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of San Diego Unified School District Flexible Spending Account Plan as amended and restated and the Summary Plan Description approved and adopted in the foregoing resolutions.

PASSED AND ADOPTED by the Board of Education of the San Diego Unified School District, San Diego, California, at a public meeting thereof duly called and held this 27th day of January 2015, by the following vote:

AYES: Barrera, Beiser, Evans, Foster, McQuary  
NAYS: None  
ABSENT: None  
ABSTAIN: None

STATE OF CALIFORNIA )  
 ) SS:  
COUNTY OF SAN DIEGO )

I, Cheryl Ward, Board Action Officer, Board of Education, San Diego Unified School District, do hereby certify that the foregoing is a full, true and correct copy of a resolution adopted by said Board at regularly called and conducted meeting thereof held on the day and by the vote above stated, which resolution is on file with the minutes of said meeting.

  
\_\_\_\_\_  
Board Action Officer, Board of Education  
San Diego Unified School District

APPROVED AS TO FORM AND LEGALITY

  
\_\_\_\_\_  
KIMBERLY CHAPIN, Assistant General Counsel II  
San Diego Unified School District

**SAN DIEGO UNIFIED SCHOOL DISTRICT  
FLEXIBLE SPENDING ACCOUNT PLAN**

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## SAN DIEGO UNIFIED SCHOOL DISTRICT FLEXIBLE SPENDING ACCOUNT PLAN INTRODUCTION

The Employer has established this Plan in order to make a broader range of benefits available to its Employees and their Beneficiaries. This Plan allows Employees to choose among different types of benefits and select the combination best suited to their individual goals, desires, and needs. These choices include an option to receive certain benefits in lieu of taxable compensation.

The Plan shall be known as San Diego Unified School District Flexible Spending Account Plan (the "Plan").

It is the intent of the Employer to establish this Plan in conformity with Section 125 of the Internal Revenue Code of 1986, as amended, and in compliance with applicable rules and regulations issued by the Internal Revenue Service. This Plan will grant to eligible Employees an opportunity to purchase qualified benefits which, when purchased alone by the Employer, would not be taxable.

### ARTICLE I DEFINITIONS

1.1 **"Administrator"** means the individual(s) or corporation appointed by the Employer to carry out the administration of the Plan. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Beneficiary"** means any person or persons designated by a participating Employee to receive any benefit payable under the Plan on account of the Employee's death

1.4 **"Benefit" or "Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any of the following:

(a) Tax Dependent: A Dependent includes a Participant's spouse and any other person who is a Participant's dependent within the meaning of Code Section 152, provided that, with respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Participant's dependent (i) is any person within the meaning of Code Section 152, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (ii) includes any child of the Participant to whom Code Section 152(e) applies (such child will be treated as a dependent of both divorced parents).

(b) Adult Children: With respect to any plan that provides benefits that are excluded from an Employee's income under Code Section 105, a Dependent includes a child of a Participant who as of the end of the calendar year has not attained age 27. A 'child' for purpose of this Section 2.04(c) means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An adult child described in this Section 2.04(c) is only a Dependent with respect to benefits provided after March 30, 2010 (subject to any other limitations of the Plan).

1.8 **"Effective Date"** means January 1, 1997.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1. An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means San Diego Unified School District and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"Entry Date"** means the date that an Employee is eligible to participate in the Plan

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

1.15 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.16 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.17 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan. **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 **"Plan"** means this instrument, including all amendments thereto.

1.20 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.22 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.23 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

## ARTICLE II PARTICIPATION

### 2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of his date of employment (or the Effective Date of the Plan, if later) and on the first day on which he satisfies the following requirements:

- (a) He/she is in a paid status in a monthly salaried position where the regular



work schedule is for half-time or more; or

(b) He/she is in a paid status in a monthly salaried position as part of a job- share assignment, regardless of the hours worked per week.

(c) He/she is not an elected official.

## 2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the date on which he satisfies the requirements of Section 2.1.

## 2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of benefits form which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

## 2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5;
- (b) **Death.** The Participant's death, subject to the provisions of Section 2.7;
- (c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 11.2; or
- (d) **Failure to pay required contributions while on a leave of absence.**

## 2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

- (a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within 90 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **Health FSA.** With regard to the Health Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses that were incurred during the portion of the Plan Year up to the end of the month after his termination except when:

- (1) Termination of employment occurs between June 1 and August 31 of the Plan Year. In that case the Participant may continue to submit claims for expenses incurred up to August 31 of the Plan Year.
- (2) Participant is laid off in June or July of the Plan Year. In that case the Participant may continue to submit claims for expenses incurred up to September 30 of the Plan Year.

(d) **Health FSA treatment.** In the event a Participant terminates his participation in the Health Flexible Spending Account during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

## 2.6 QUALIFYING LEAVE UNDER FAMILY 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 existing coverage under the Plan on the same terms and conditions as though he were still an active Employee. If the Employee opts to continue his coverage, the Employee may pay his Elective Contribution with after-tax dollars while on leave (or pre-tax dollars to the extent he receives compensation during the leave. 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.

## 2.7 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent.

**ARTICLE III  
CONTRIBUTIONS TO THE PLAN**

**3.1 SALARY REDIRECTION**

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

**3.2 APPLICATION OF CONTRIBUTIONS**

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

**3.3 PERIODIC CONTRIBUTIONS**

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections to the Health Flexible Spending Account are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.5.

**ARTICLE IV  
BENEFITS**

**4.1 BENEFIT OPTIONS**

Each Participant may elect any one or more of the following optional Benefits:

- (1) Health Flexible Spending Account
- (2) Dependent Care Flexible Spending Account
- (3) Premium Expense Reimbursement Account
  - (i) Health Insurance Benefit
  - (ii) Other Insurance Benefit

**4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

**4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

**4.4 HEALTH INSURANCE BENEFIT**

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

**4.5 OTHER INSURANCE BENEFIT**

(a) **Employer selects contracts.** The Employer may select additional health or other policies allowed under Code Section 125 or allow the purchase of additional health or other policies by and for Participants, which policies will provide uniform benefits for all Participants electing this Benefit.

(b) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from any additional Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

#### **4.6 NONDISCRIMINATION REQUIREMENTS**

In accordance with Code Section 125(b)(1), (2), and (3), this Plan is intended not to discriminate in favor of Highly Compensated Participants (as defined in Code Section 125(e)(1)) as to contributions and benefits nor to provide more than 25% of all qualified benefits to Key Employees. If, in the judgment of the Administrator, more than 25% of the total nontaxable benefits are provided to Key Employees, or the Plan discriminates in any other manner (or is at risk of possible discrimination), then, notwithstanding any other provision contained herein to the contrary, and, in accordance with the applicable provisions of the Code, the Administrator shall, after written notification to affected Participants, reduce or adjust such contributions and benefits under the Plan as shall be necessary to insure that, in the judgment of the Administrator, the Plan shall not be discriminatory.

### **ARTICLE V PARTICIPANT ELECTIONS**

#### **5.1 INITIAL ELECTIONS**

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

#### **5.2 SUBSEQUENT ANNUAL ELECTIONS**

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

### 5.3 FAILURE TO ELECT

Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

### 5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) **Employment Status:** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) **Residency:** A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits

under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in



the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

## ARTICLE VI HEALTH FLEXIBLE SPENDING ACCOUNT

### 6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

### 6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(c) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

### 6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

### 6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, no more than \$2,500 may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year.

### 6.5 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

### 6.6 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Uniform Coverage Rule and Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Claim Procedure.** In order to be reimbursed for any medical expenses incurred during the Plan Year, the Participant shall complete the form(s) provided for such purpose by the Administrator. The Participant shall submit the completed form to the Administrator with an original bill or other proof of the expense acceptable to Administrator. No reimbursement shall be made on the basis of an incomplete form or inadequate evidence of expense as determined by the Administrator. Forms for reimbursement of Eligible Medical Expenses must be submitted no later than the

ninetieth (90th) day following the last day of the Plan Year during which the Eligible Medical Expenses were incurred. Reimbursement payments shall only be made to the Participant, or the Participant's legal representative in the event of incapacity or death of the Participant.

(d) Use of Debit Card: In the event that the Employer elects to allow the use of debit cards ("Debit Cards") for reimbursement of Eligible Medical Expenses under the Medical Expense Reimbursement Plan, the provisions described in this Section shall apply.

1. Substantiation. The following procedures shall be applied for purposes of substantiating claimed Eligible Medical Expenses after the use of a Debit Card to pay the claimed Eligible Medical Expense:
  - (i) If the dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment for that service under the Employer's major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review.
  - (ii) If the merchant, service provider, or other independent third-party (e.g., pharmacy benefit manager), at the time and point of sale, provides information to verify to the Administrator (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review.
2. Status of Charges. All charges to a Debit Card, other than co-payments and real-time substantiation as described in Subsection (a) above, are treated as conditional pending confirmation of the charge, and additional third-party information, such as merchant or service provider receipts, describing the service or product, the date of the service or sale, and the amount, must be submitted for review and substantiation.
3. Correction Procedures for Improper Payments. In the event that a claim has been reimbursed and is subsequently identified as not qualifying for reimbursement, one or all of the following procedures shall apply:
  - (i) First, upon the Administrator's identification of the improper payment, the Eligible Employee will be required to pay back to the Plan an amount equal to the improper payment.
  - (ii) Second, where the Eligible Employee does not pay back to the Plan the amount of the improper payment, the Employer will have the amount of the improper payment withheld from the Eligible Employee's wages or other compensation to the extent consistent with applicable law.
  - (iii) Third, if the improper payment still remains outstanding, the Plan

may utilize a claim substitution or offset approach to resolve improper claims payments.

(iv) If the above correction efforts prove unsuccessful, or are otherwise unavailable, the Eligible Employee will remain indebted to the Employer for the amount of the improper payment. In that event and consistent with its business practices, the Employer may treat the payment as it would any other business indebtedness.

(v) In addition to the above, the Employer and the Plan may take other actions they may deem necessary, in their sole discretion, to ensure that further violations of the terms of the Debit Card do not occur, including, but not limited to, denial of access to the Debit Card until the indebtedness is repaid by the Eligible Employee.

4. Intent to Comply with Rev. Rul. 2003-43. It is the Employer's intent that any use of Debit Cards to pay Eligible Medical Expenses shall comply with the guidelines for use of such cards set forth in Rev. Rul. 2003-43, and this Section 8.05 shall be construed and interpreted in a manner necessary to comply with such guidelines.

## 6.7 OTHER TERMS AND CONDITIONS

(a) COBRA. To the extent required by Section 4980B of the Code and Sections 601 through 607 of ERISA ("COBRA"), a Participant and a Participant's Dependents shall be entitled to elect continued participation in this Medical Expense Reimbursement Plan only through the end of the plan year in which the qualifying event occurs, by contributing monthly (from their personal assets previously subject to taxation) to the Employer/Administrator, 102% of the amount of desired reimbursement through the end of the Plan Year in which the qualifying event occurs. Specifically, such individuals will be eligible for COBRA continuation coverage only if they have a positive Medical Expense Reimbursement Account balance on the date of the qualifying event. Participants who have a deficit balance in their Medical Expense Reimbursement Account on the date of their qualifying event shall not be entitled to elect COBRA coverage. In lieu of COBRA, Participants may continue their coverage through the end of the current Plan Year by paying those premiums out of their last paycheck on a pre-tax basis.

(b) Uniformed Services Employment and Reemployment Rights Act. Notwithstanding anything to the contrary herein, this Medical Expense Reimbursement Plan shall comply with the applicable provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (Public Law 103-353).

**ARTICLE VII  
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

**7.1 ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

**7.2 DEFINITIONS**

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of participant's Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section

7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

### **7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

### **7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

## **7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.10 hereof.

## **7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in Section 7.8 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

## **7.7 FORFEITURES**

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.10 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

## **7.8 LIMITATION ON PAYMENTS**

Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

## **7.9 COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

## **7.10 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

**ARTICLE VIII  
PREMIUM EXPENSE REIMBURSEMENT ACCOUNT**

**8.1 PURPOSE**

The Premium Expense Reimbursement Account allows eligible employees to use tax-free dollars to pay for certain premium expenses under various programs that the District offers eligible employees. These premium expenses include:

- (1) Health care premiums under the District insured group medical plan
- (2) Other insurance coverage the District may provide

**ARTICLE IX  
BENEFITS AND RIGHTS**

**9.1 CLAIMS REVIEW PROCEDURE**

This provision shall apply only to the extent that a claim for benefits is not governed by a similar provision of a benefit program available under this Plan.

(a) Initial Claim for Benefits. Each Participant may submit a claim for benefits to the Administrator as provided in Section 6.6 AND 7.10. A Participant shall have no right to seek review of a denial of benefits, or to bring any action in any court to enforce a claim for benefits prior to his filing a claim for benefits and exhausting his rights to review under this section.

When a claim for benefits has been filed properly, such claim for benefits shall be evaluated and the claimant shall be notified of the approval or the denial within (90) days after the receipt of such claim unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period which shall specify the special circumstances requiring an extension and the date by which a final decision will be reached (which date shall not be later than one hundred and eighty (180) days after the date on which the claim was filed.) A claimant shall be given a written notice in which the claimant shall be advised as to whether the claim is granted or denied, in whole or in part. If a claim is denied, in whole or in part, the claimant shall be given written notice which shall contain (a) the specific reasons for the denial, (b) references to pertinent plan provisions upon which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (d) the claimant's rights to seek review of the denial.

(b)Review of Claim Denial. If a claim is denied, in whole or in part, the claimant shall have the right to request that the Administrator review the denial, provided that the claimant files a written request for review with the Administrator within sixty (60) days after the date on which the claimant received written notification of the denial. A claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Administrator. Within sixty (60) days after a request is received, the review shall be made and the claimant shall be advised in writing of the decision on review, unless special circumstances require an extension of time for processing the review, in which



case the claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred and twenty (120) days after the date on which the request for review was filed.) The decision on review shall be forwarded to the claimant in writing and shall include specific reasons for the decision and references to plan provisions upon which the decision is based. A decision on review shall be final and binding on all persons.

(c) Exhaustion of Remedies. If a claimant fails to file a request for review in accordance with the procedures herein outlined, such claimant shall have no rights to review and shall have no right to bring action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

## **9.2 APPLICATION OF BENEFIT PLAN SURPLUS**

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

## **ARTICLE X ADMINISTRATION**

### **10.1 PLAN ADMINISTRATION**

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid

discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

(f) To approve reimbursement requests and to authorize the payment of benefits;

(g) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

#### **10.2 EXAMINATION OF RECORDS**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

#### **10.3 PAYMENT OF EXPENSES**

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

#### **10.4 INSURANCE CONTROL CLAUSE**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

#### **10.5 INDEMNIFICATION OF ADMINISTRATOR**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

**ARTICLE XI  
AMENDMENT OR TERMINATION OF PLAN**

**11.1 AMENDMENT**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

**11.2 TERMINATION**

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

**ARTICLE XII  
MISCELLANEOUS**

**12.1 PLAN INTERPRETATION**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

**12.2 GENDER AND NUMBER**

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

**12.3 WRITTEN DOCUMENT**

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

**12.4 EXCLUSIVE BENEFIT**

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

## **12.5 PARTICIPANT'S RIGHTS**

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

## **12.6 ACTION BY THE EMPLOYER**

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

## **12.7 EMPLOYER'S PROTECTIVE CLAUSES**

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

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

## **12.8 NO GUARANTEE OF TAX CONSEQUENCES**

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

## **12.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS**

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

#### **12.10 FUNDING**

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

#### **12.11 GOVERNING LAW**

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

#### **12.12 SEVERABILITY**

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

#### **12.13 CAPTIONS**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

#### **12.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

#### **12.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

#### **12.16 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

## **12.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS**

**12.17.1 Application.** If the Health Flexible Spending Account under this Cafeteria Plan is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

**12.17.2 Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

**12.17.3 PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

**12.17.4 PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

- (ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- (iii) mitigation of any harm caused by the breach, to the extent practicable; and
- (iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

**12.17.5 Certification.** The Employer must provide certification to the Plan that it agrees to:

- (1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the

purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

### 12.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

**12.18.1 Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.


**12.18.2 Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

**12.18.3 Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

IN WITNESS WHEREOF, this Plan document is hereby executed this 27 day of January 2015

San Diego Unified School District

By   
EMPLOYER

Approved in public meeting of the  
Board of Education of the San Diego  
Unified School District on 1/27/15  
  
Cheryl Ward, Board Action Officer,  
Board of Education



ADOPTING RESOLUTION

The undersigned Principal of San Diego Unified School District (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on \_\_\_\_\_, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended Cafeteria Plan including a Dependent Care Flexible Spending Account and Health Flexible Spending Account effective January 1, 2015, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Cafeteria Plan by delivering to each employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to this meeting, which form is hereby approved.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of San Diego Unified School District Flexible Spending Account Plan as amended and restated and the Summary Plan Description approved and adopted in the foregoing resolutions.

\_\_\_\_\_  
Principal

Date: \_\_\_\_\_

**SAN DIEGO UNIFIED SCHOOL DISTRICT  
FLEXIBLE SPENDING ACCOUNT PLAN  
SUMMARY PLAN DESCRIPTION**

## SAN DIEGO UNIFIED SCHOOL DISTRICT FLEXIBLE SPENDING ACCOUNT PLAN

### INTRODUCTION

This Summary Plan Document (SPD) provides a summary of the following benefits:

- Health Flexible Spending Account Plan
- Dependent Care Flexible Spending Account Plan
- Premium Expense Reimbursement Account

Throughout this SPD, these plans will be referred to as the Flexible Spending Account (FSA) or the Plan. The Plan is only available to covered employees and their dependents. The Plan allows covered employees to set money aside to pay for eligible medical expenses and dependent care expenses, on a pre-tax basis. Each covered person's rights under the Plan are legally enforceable. You may not assign, or in any way transfer your rights, under the Plan.

Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan.

The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control.

If you wish to receive a copy of the legal Plan document, please contact the District.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information".

**This booklet is for covered participants entering the Plans on or after January 1, 2015.**

## I BENEFITS

**The Health Flexible Spending Account Plan** allows you to set aside part of your salary on a pre-tax basis to help pay for eligible health care expenses each year. Examples of eligible expenses include medical and dental care, as well as vision expenses for you, your spouse and your dependents. As you pay for these expenses, your FSA will pay you back.

Each year during open enrollment, you can elect to set aside pre-tax dollars up to \$2,500. This money will be deposited into your health spending account for the year. The total amount you decide to set aside is taken out of your paycheck in equal amounts throughout the year.

**The Dependent Care Flexible Spending Account Plan** allows you to set aside part of your salary on a pre-tax basis to help pay for eligible dependent care services each year. It covers eligible day care expenses for your dependent children under age 13. It may also be used for the care of other dependents, if they are considered your dependent for income tax purposes, if such individual is mentally or physically handicapped and incapable of self-care.

Each year during open enrollment, you choose to set aside pre-tax dollars up to \$5,000. This money will be deposited into your dependent care spending account. If your spouse also participates in a dependent care spending account, the tax-free benefit is limited to \$5,000 for both of you combined. If you are married but filing taxes separately, the tax-free benefit is limited to \$2,500. The total amount you decide to set aside is taken out of your paycheck in equal amounts throughout the year.

**The Premium Expense Reimbursement Account** allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Other insurance coverage that we may provide.

## II ELIGIBILITY

You do not have to participate in the Plan, it is completely voluntary. You can choose to participate by setting aside part of your salary on a pre-tax basis into these accounts. Each account is managed separately, so you can enroll in none, one, or all of the accounts.

### Eligibility

You will be eligible to join the Plan as of your date of hire with us and on the first day on which you satisfy the following requirements:

- a) You are in a paid status in a monthly salaried position where the regular work schedule is for half-time or more; or

- b) You are in a paid status in a monthly salaried position as part of a job-share assignment, regardless of the hours worked per week.
- c) You are not an elected official

## **When Your Participation Begins**

**Newly Eligible Employees.** In order to qualify for FSA benefits, you must enroll and agree to make the required pre-tax payroll deduction deposits to your account(s). If you want to participate in one or more of the Flexible Spending Accounts, you must enroll within the first 31 days you are eligible. Please see the Employee Benefits Department or the Employee Benefits website for the enrollment form. Your participation will begin the first day administratively feasible.

If you do not enroll within the first 31 days of eligibility, you will have to wait until the next Annual Open Enrollment Period to enroll (described below). The only exception is if you have a Change in Status which is also described below.

**Annual Open Enrollment Period.** Once a year, the District sponsors an Annual Open Enrollment Period. During this time, you can choose to enroll or re-enroll for FSA participation for the following year. This election will go into effect on the first January 1 following the Annual Open Enrollment Period. **You must re-enroll for the Flexible Spending Accounts each year if you wish to continue to remain enrolled. You can do so during the Annual Open Enrollment Period.**

**Changing or Canceling Your Participation.** FSA elections are for the entire Plan Year (as defined in the General Information section of this SPD). You can change or cancel your participation only during the Annual Open Enrollment Period, unless you have a Change in Status. This applies to:

- The account(s) you've elected to participate in; and
- The amount of your pre-tax payroll-deduction deposits to your account(s).

**Change in Status.** If you have a qualified Change in Status, you can make these changes to your FSA:

- Increase or decrease the amount of your pre-tax contribution (but not below the amount already reimbursed);
- Cancel your participation; or
- Choose to participate in one or more of the accounts.

The Change in Status must be applicable to the plan for which you are requesting the change and the requested change must be on account of and consistent with the Change in Status.

These are examples of a qualified Change in Status:

- Gaining or losing a spouse (through marriage, divorce, or death);
- Gaining or losing a dependent (through birth, adoption, placement for adoption, death, or loss of eligibility as a dependent);
- Commencement or termination of an adoption proceeding;

- Change in the employment status of you, your spouse, or your dependent that causes a change in eligibility (examples: changing from part-time to full time, or changing from hourly to salaried); and
- Change in cost or coverage of dependent care (e.g. change from one-child care center to another and the new child-care center charges a different rate).

If you have a Change in Status, the change to your FSA election(s) will be effective as of the date you request the change. Remember, you must apply for the change within 31 days of the birth, adoption or the loss of a dependent's eligibility, etc. If you don't enroll within 31 days of the Change in Status event, you will have to wait until the next Annual Open Enrollment Period. If you have any questions about making a mid-year plan change due to a Change in Status, please contact your Employer.

**Leave of Absence.** Special rules apply to FSA participation when you are on a leave of absence. Please contact the District for details about your rights and responsibilities during your leave and your return to work. If your unpaid leave is covered under the Family and Medical Leave Act, you can continue your Health Care FSA participation during your period of leave. All you have to do is make after-tax contributions equal to the amount you were contributing on a pre-tax basis.

The Plan provides for reinstatement of coverage to persons returning to employment after military service, to the extent required by federal law. If you are re-hired after a period of uniformed service that entitles you to rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA), you will be eligible for reinstatement under the Plan. Contact your Employer for further information

### III

#### HOW YOUR PLAN OPERATES

As a participant in the FSA, you are choosing to deposit part of your salary on a pre-tax basis in one or more of the following accounts:

- Health Flexible Spending Account,
- Dependent Care Flexible Spending Account,

During the year, your FSA can pay you back for eligible expenses. The term eligible expenses is important because your expenses must meet specific requirements to qualify for reimbursement under the Plan. For more details on eligible health care expenses you can go to the IRS Publication 502, "Medical and Dental Expenses." You can get a copy of this document by contacting your local IRS office or online at [www.irs.gov](http://www.irs.gov).

You may submit a claim form for reimbursement for eligible expenses up to 90 days after the plan year in which your expense was incurred. All expenses must be incurred by December 31 of the plan year in which you are participating. For the Health Flexible Spending Account, you may elect to receive a debit card that can be used for eligible expenses. You should maintain all receipts in the event your charge needs to be substantiated.

## IV CONTRIBUTIONS

The amount(s) you choose to contribute to your account(s) are made through convenient pre-tax payroll deductions.

The following chart shows your minimum and maximum allowable FSA enrollment contributions.

Account	Minimum Enrollment Amount	Maximum Enrollment Amount
Health Flexible Spending Account	\$0	\$2,500
Dependent Care Flexible Spending Account	\$0	\$5,000 per calendar year (\$2,500 per calendar year if you are married and you and your spouse file separate tax returns)

## V BENEFIT PAYMENTS

During the course of the Plan Year, you may submit requests for reimbursement of eligible expenses you have incurred. Expenses are considered incurred when the service is performed, not when it is paid for.

### HEALTH FLEXIBLE SPENDING ACCOUNT

You can use your Health FSA to pay for a wide range of health care expenses if:

- The claim is for an eligible health care expense that is not reimbursable by any other source;
- You have the documents you need to support your claim; and
- The claim takes place while you are participating in the FSA (unless you elect Continuation of Coverage as described below)

**Amount of Reimbursement.** You can file claims up to your total election amount at any time during the year regardless of the amount in your account at the time of request. For information about eligible expenses you may log on to your member home page on the Administrator website. For more details on eligible health care expenses you can go to the IRS Publication 502, "Medical and Dental Expenses." You can get a copy of this document by contacting your local IRS office or online at [www.irs.gov](http://www.irs.gov).

**Tax Deductions.** If you use your Health FSA to pay for a specific health care expense, you cannot claim the same expense as a deduction on your income tax return. In addition, you may have to pay income taxes on any amount paid back to you for an ineligible expense.

## Claims Reimbursements Instructions

**Health Care Debit Card.** The health care debit card may be used to pay for eligible health care expenses that will not be paid under your medical benefit plan or dental benefit plan. This would include things like your deductible, copayment and coinsurance. Eligible expenses will automatically be deducted from your FSA balance. In some instances you may be required to provide additional information regarding your debit card purchase. You can enroll for a debit card during Open Enrollment or when you first become eligible.

**Manual Claims Submission.** If you do not elect to use a Health FSA debit card, you must send in a claim for reimbursement to the Administrator. All claims must be sent in with a completed "Expense Reimbursement Voucher" which can be found at [www.afadvantage.com](http://www.afadvantage.com) or upon request at the Employee Benefits Department offices. Claims are paid based on the amount originally submitted.

If you are overpaid, the Plan can ask you to refund the amount of the overpayment or the Plan can offset future reimbursements until the overpayment is recovered.

### Health Care Spending Account Unused Contributions

Expenses sent in more than three months after the end of the Plan Year are not eligible for reimbursement from your FSA. The deadline for sending in claims that took place in the Plan Year is March 31 of the following Plan Year.

Any monies left in your account after March 31 following the Plan year will be forfeited as required by law.

### Termination of Coverage

If you terminate employment and have funds left in your health spending account, you can submit claims for any eligible expenses you had before your employment ended. You will lose any remaining funds. You can elect to keep using your FSA until all of your money is spent for the rest of the Plan Year by choosing COBRA continuation coverage. The terms of COBRA continuation coverage will apply (see the "**Continuation of Coverage**" section for more details). If you do not elect COBRA continuation, you may send in spending account claims under the following rules:

- You can only send in claims for expenses that happened during your participation in the Plan Year; and
- All claims must be sent in before March 31 of the following Plan Year.



## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

You can only use your Dependent Care FSA to pay for eligible dependent care expenses. Eligible dependent care expenses are those that are necessary for you (or you and your spouse) to work outside the home.

Your dependent care claims must meet four requirements before they can be approved:

- Your claim must be for the care of an eligible dependent;
- The care provided must be for an eligible dependent care expense;
- You cannot be reimbursed for more than the amount in your Dependent Care FSA at any given time; and
- Your claim must be supported by appropriate documentation. This includes the name, address, and Social Security number or (Taxpayer Identification Number) of the dependent care provider.

***If you are married and your spouse does not earn any income, you are not eligible for dependent care benefits unless your spouse is a full-time student, is actively looking for a job, or is disabled and unable to provide for his or her own care. Your spouse is considered to be a full-time student if he or she goes to school for at least five months a year.***

**Amount of Reimbursement.** You may be reimbursed from your Dependent Care FSA for eligible dependent care expenses for any dependent that meets the requirements below. To be eligible, the dependent care expenses must allow you and, if you are married, (your spouse) to work or look for work. The only exception to this rule is if your spouse is a full-time student or is physically or mentally unable of self-care at the time of the expenses.

**Who is an Eligible Dependent?** Each dependent that you claim dependent care expenses for must be:

- A person under age 13 that you claim as a dependent on your federal tax return; or
- A spouse or a person (other than a child under 13) who is your dependent under federal tax law, but only if he or she is physically or mentally incapable of self-care.

**Who may Provide Eligible Dependent Care Services?** If you want to be reimbursed from your Dependent Care FSA, services must be provided by:

- A dependent care center (that is, a facility that provides care for more than six individuals that do not live at the facility.) The care center must comply with all state and local laws and regulations. In most cases, this means the facility is licensed; or
- An educational institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for Federal Tax purposes.

**What Types of Dependent Care Services May be Reimbursed?** Generally, eligible dependent care services are services that provide for the dependent's well-being and protection. In most cases, it does not include food, clothing or education. It does not include expenses for education of a dependent in kindergarten or any higher grade. It does not include expenses for overnight camp. The following are examples of services that may be reimbursed:

- The reimbursement is for an eligible dependent, that dependent is under age 13, or meets the “Qualifying Person Test” as described in IRS Publication 503 (go to irs.gov to view IRS Publication 503).
- If the reimbursement is for care for your spouse, your spouse is physically or mentally incapable of self-care, and has the same primary home as you for more than half the year.
- Reimbursement can only be made for services that have already been provided whether or not they are billed or paid.
- Dependent care expenses must be provided to allow you and your spouse (if married) to work or actively look for work. Your spouse is considered working if he or she is, a full-time student at an educational organization, or physically or mentally incapable of self-care.

**Dependent Care Tax Credit.** Under current law, you can take a federal dependent care tax credit for part of your dependent-care expenses if dependent care is needed so that you and your spouse can work outside the home. If you use your Dependent Care FSA to pay for a dependent care expense, you cannot claim the federal dependent care tax credit for the same expense. Remember that the maximum amount of the federal dependent care-tax credit available to you each year will be reduced by the amount you chose to deposit in your Dependent Care FSA for that year.

**Which Tax Break Is Better?** The answer to this question depends on your personal situation, including your taxable income, number of dependents and the amount you pay for dependent care. Keep in mind that your taxable income (W-2 pay) will be reduced by your Dependent Care FSA deposits during a given calendar year. You can estimate the amount of your federal dependent care tax credit by referring to the worksheet and instructions on IRS Form 2441. This information also appears on IRS Form 1040A (Schedule 1) and instructions. You can get either of these forms by contacting your local IRS office. You may also wish to talk with a tax advisor.

#### **Claims Reimbursements Instructions**

To get reimbursed, you must submit a claim to your FSA. All claims must include a completed Dependent Day Care Reimbursement Form and any required certifications and signatures. You can get Dependent Day Care Reimbursement Forms online at [www.afadvantage.com](http://www.afadvantage.com) or upon request at the Employee Benefits Department offices.

**Dependent Care Spending Account Unused Contributions.** Expenses sent in more than three months after the end of the Plan Year are not eligible for reimbursement from your FSA. **The deadline for sending in claims that took place in the Plan Year is March 31 of the following Plan Year.**

You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the account to cover your request.

Any monies left at the end of the Plan Year will be forfeited.

## **VI CONTINUATION OF COVERAGE**

Continuation of Coverage means your right under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) to continue your health care spending account coverage that was in place

the day before a Qualifying Event, as defined below, if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of the Qualifying Event.

A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- Your death;
- Divorce or separation from your spouse;
- Your becoming entitled to receive Medicare benefit; or Your dependent ceasing to be a dependent.

For a qualifying event other than a change in your employment status or death, it will be your obligation to inform the District within 60 days of its occurrence. The District, in turn, will furnish you (and your spouse, as the case may be) with a separate, written option to continue the coverage provided at stated contribution costs. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

Only participants that have positive balances in their health care spending account at the time of a Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event) will be eligible for COBRA coverage. You will be notified if you are eligible for COBRA coverage. Even if COBRA coverage is offered for the year in which the Qualifying Event occurs, COBRA coverage for your health care spending account will cease at the end of the year and will not be carried over for the next Plan Year. You may pay contributions for COBRA coverage on an after tax basis.

**Procedures for Providing Notices Required Under This Continuation of Group Coverage Section**

You must comply with the time limits for providing notices required in paragraph above. Your notice must be in writing and contain at least the following information:

- The names of the eligible employee and eligible dependents;
- The qualifying event; and
- The date on which the qualifying event (if any) occurred.

**VII**  
**GENERAL INFORMATION**

This Section contains certain general information which you may need to know about the Plan.

**General Information:**

Plan Name:	San Diego Unified School District Flexible Spending Account Plan is the name of the Plan
Plan Number:	501
Employer Identification Number:	95-6002781
Original Effective Date:	January 1, 1997.
Employer Information	San Diego Unified School District 4100 Normal Street San Diego, California 92103
Plan Administrator	San Diego Unified School District 4100 Normal Street San Diego, California 92103 619-725-7717
Service of Legal Process	San Diego Unified School District 4100 Normal Street San Diego, California 92103
Type of Administration	Employer Administration'
Claims Submission	American Fidelity Assurance Company PO Box 25510 Oklahoma City, OK 73125-0510 Phone 800-325-3748 Fax: 1-800-543-3539 <a href="http://www.afadvantage.com">www.afadvantage.com</a>

The Plan Year begins on January 1 and ends on December 31.

## VII ADDITIONAL PLAN INFORMATION

### HIGHLY COMPENSATED AND KEY EMPLOYEES

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the District each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

### CLAIM DENIALS

The Plan manager will deny a claim for a benefit when the claim is judged not to be in accordance with the provisions of the Plan. If your claim is denied, the Plan manager will provide you with a written notice of the denial within 30 days (or 45 days in special circumstances with notice to you) after they receive your claim. The notice will explain the specific reason for the denial, reference the Plan provision on which the denial is based, and provide additional information regarding the appeal process.

**Claims Appeal Process.** If your claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision.

You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

San Diego Unified School District  
Employee Benefits Department  
4100 Normal Street, Room 1150  
San Diego, California 92103

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan manager will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

### **ACCESS TO RECORDS AND CONFIDENTIALITY (This Section Applies to the Health Care FSA Plan)**

The District complies with applicable state and federal laws governing the confidentiality and use of protected health information and medical records. The District is also allowed to use your protected health information when necessary, for proper administration of the Plan.

In the event that protected health information is disclosed to the District, the District may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated there under and as amended including, certain Plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the District upon receipt, by the Plan, of a certification from the District to the amendment of the Plan documents and that your District agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment – related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your Employer;
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;
- Make information available to fulfill your right to access your protected health information;
- Make the information available for amendment or to incorporate applicable amendments;
- Make the information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Human Services to determine compliance with HIPAA;
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your Employer are permitted access to your protected health information for Plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health Plan;

- Ensure adequate separation between the Plan and your Employer is supported by reasonable and appropriate security measures.

Certain limited information of all family members enrolled in the Plan will be viewable on the FSA website by the enrolled employee. By enrolling in the FSA Plan you are acknowledging that you and all dependents enrolled in the Plan, understand that you, as the enrolled employee, will have access to limited information about all the claims submitted to your FSA account for reimbursement.

#### **AMENDMENT OR TERMINATION OF THE PLAN**

The District has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified. The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any non-forfeitable right to continued participation in any benefits plan.