

**SUMMARY PLAN DESCRIPTION  
FLEXIBLE BENEFIT PLAN**

**SECTION 125 PLAN**

**CARROLLTON-FARMERS BRANCH ISD**

**Effective January 1, 2003  
Revised January 1, 2008**

**SUMMARY PLAN DESCRIPTION  
FLEXIBLE BENEFITS PLAN**

**FOR THE SECTION 125 PLAN FOR EMPLOYEES OF  
CARROLLTON-FARMERS BRANCH ISD**

**Introduction**

Your employer (the "District" or "Employer") is pleased to sponsor an employee benefit program known as a "flexible benefit plan" (the "Plan") for you. The Plan provides you with the opportunity to use pre-tax dollars to pay for your portion of the costs under certain of the health plans offered by the District by entering into a salary reduction arrangement instead of a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save income taxes on the amount of your salary reduction. The Plan also permits you to pay for certain other medical and dependent care expenses on a pre-tax basis.

This booklet describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan and a brief description of your rights as a participant. It is not a part of the official Plan Document. If there is a conflict between the Plan Document and this booklet, the Plan Document will apply.

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## **Part I**

### **General Information about the Flexible Benefit Plan**

#### **Questions & Answers**

**1. What is the purpose of the Plan?**

The purpose of the Plan is to allow eligible employees to use funds provided by the District through employee salary reduction and to choose and pay for one or more of the benefits offered through the Plan.

**2. What is meant by salary redirection or reduction?**

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

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

By allowing you to pay for certain benefits with pre-tax income, the Plan reduces the amount you must pay in federal income taxes. Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are not taxable to you under present law. However, neither the District nor the Plan Administrator can guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser.

**4. When did the Plan take effect?**

The Initial Plan became effective May 1, 1986. The effective date for this revision is January 1, 2008.

**5. Who can participate in the Plan?**

You can participate if you are an employee who is in a permanent status (as defined by the District) and are regularly scheduled to work at least 20 hours per week and eligible to participate in the Carrollton-Farmers Branch ISD Health Benefit Plan.

Those employees who actually participate in the Plan are called "Participants." An employee continues to participate until he/she is no longer employed by the District, Continuation Coverage (as described below) is no longer in effect, or you elect not to participate.

## **6. What benefits are offered through the Plan?**

The Plan has three (3) major types of benefits:

- (a) Medical Reimbursement Benefit – allows you to set aside a fixed amount of your pay on a pre-tax basis in order to pay for eligible medical expenses (for details see Part II)
- (b) Dependent Care Expense Reimbursement Benefit – allows you to set aside a fixed amount of your pay on a pre-tax basis to pay for eligible work-related dependent care expenses (for details see Part III).
- (c) Insurance Premium Plan – allows your portion of the premiums for certain health plans sponsored by the District to be made on a pre-tax basis (see part IV).

## **7. How do I become a Participant?**

You become a Participant by signing an Individual Election/Enrollment Form (the "Enrollment Form") on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits you elect. You will be provided an Enrollment Form when you first become eligible to participate.

As a new employee, you will have thirty (30) days in which to complete the Form and turn it in to Personnel. If you are a new employee, you may become a Participant on the first day of the month following the date when you have met the eligibility requirements described in Answer #5 above.

You must sign and return the election form in order to participate in the medical reimbursement and dependent care portions of the Plan. Unless you complete and return the form and specifically elect not to participate in the Plan, your portion of the premiums for medical, dental and vision plans covered by the Flexible Benefit Plan will automatically be made on a pre-tax basis.

During open enrollment periods, unless you complete, sign, and file a Benefit Election Form as required, you will have been deemed to have elected to continue the benefits and coverages in effect for the prior Plan Year, but will not be eligible to participate in either spending account.

## **8. What are the enrollment periods for entering the Plan?**

The initial period for enrolling in the Plan is the 30-day period immediately proceeding the date you are eligible to participate. Thereafter, the annual election period will be prior to January 1 of each year. The District will announce the dates of the enrollment election period each year before the period begins.

## 9. Can I change my election during the Plan Year?

Generally, you cannot change your election of whether or not to participate in the Plan or vary the benefits you have selected during the Plan Year. Your election will terminate if you are no longer working for the District or, in the case of the Medical Expense Reimbursement Plan described below, you do not pay the required contributions for the benefit you have elected. Otherwise, you may change your elections only during the month of the annual Open Enrollment Period and then only for the coming Plan Year.

There are important exceptions to this general rule:

- a. If you elected health insurance coverage, you will be able to revoke this previous election and make a new election if:
  - your legal marital status changes through marriage, death of your spouse, divorce, or annulment;
  - the number of dependents you have for federal income tax purposes changes due to birth, adoption, placement for adoption, or death;
  - you, your spouse, or any other dependent, begins or ends employment;
  - you, your spouse, or a dependent experiences a reduction or increase in hours of employment, including a switch between part-time and full-time, a strike or lockout, or beginning or end of an unpaid leave of absence;
  - a dependent of yours satisfies or no longer satisfies the requirements for health insurance coverage due to attainment of age or any similar circumstance as provided in the accident or health plan under which you are covered as an Employee;
  - you, your spouse, or any of your dependents changes the place of residence or work and that change affects your coverage; and
  - (only with regard to your health insurance election) you, your spouse, or one of your covered dependents becomes covered by the District's group health plan as a special enrollee under Code Sec. 9801(f). (The District will furnish you with information as to the special enrollment rights that Employees and their dependents have with regard to entry into the health insurance plan at nonstandard enrollment times.).

You may revoke your health insurance election under this Plan and make a new election for the rest of the Plan Year only if any of the changes in status listed above results in the gain or loss of health insurance coverage by you, your spouse, or any of your dependents, and the new election reflects that gain or loss.

If you, your spouse, or any dependent becomes eligible for COBRA continuation coverage under the Employer's group health plan as provided in Code Sec. 4980B or any similar state law, you may elect to increase payments under this Plan in order to pay for the continuation coverage.

- b. You may change or revoke your previous election on benefits **other** than health insurance coverage at any time during the Plan Year and make a new election if there are one or more of the following significant changes in your family status –
- your marriage or divorce.
  - birth or adoption of your child.
  - death of your spouse or child.
  - a significant change in the medical benefits or premiums available either to you, through your employment with the District or to your spouse, through his/her employer. If you otherwise are entitled to revoke an election or make an alternate election by reason of an increase in health insurance costs, you must do so within 31 days of receipt of written notice from the Plan Administrator of the significant change in cost or composition of the benefit originally elected.
  - termination of your employment, your spouse's employment, or change of either you or your spouse's employment status from full-time to part-time, or vice versa, or if either of you take an unpaid leave of absence from work.
- c. You also may revoke any election you made for the period during which you are absent from work for a family medical leave covered by the federal Family and Medical Leave Act (FMLA). You may reinstate your election of group medical benefits when you return from the FMLA leave. However you may not reinstate a revoked election as to any non-health insurance benefits until the next regular Open Enrollment Period.
- d. Additionally, the Plan Administrator may modify your election(s) downward during the Plan Year if you are a highly-compensated employee of the District or if you are a member of the "highly paid" group of employees (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

**10. Can I change the amount of my salary reduction contribution if I terminate employment and am rehired in the same plan year?**

- With respect to an election that is **not** related to an accident or health plan, you cannot make a new benefit selection within the same plan year that you terminate employment and revoke your existing benefits elections;
- With respect to an election that is related to an accident or health plan:
  - you may have the election automatically reinstated if you resume employment within 31 days of your termination of employment, unless there has been another intervening event that would permit a change in election.

**11. What are my "Individual Benefit Accounts"?**

If you elect benefits under the Plan, one or more Individual Benefit Accounts ("Accounts") will be set up in your name to keep a record of the benefits to which you are entitled. How many accounts that are established depends on what benefits you have elected. For example, if you have chosen to participate in the Medical Expense Reimbursement Plan, the Dependent Care Expense Reimbursement Plan, and in one or more of the Insurance Plans, three (3) accounts will be maintained in your name.

**12. How are my Accounts funded?**

When you complete the Initial Enrollment Form or the annual Open Enrollment Form, you specify which benefits you wish to pay for through salary reduction. Thereafter, your accounts will be credited with that portion of your gross income you have elected to forego through salary reduction. These portions will be credited as of each pay period.

The total amount that may be credited collectively to your accounts during any one Plan Year will be limited to \$5,000 for the Medical Reimbursement Plan and \$5,000/2,500 for the Dependent Care Expense Plan.

The amount that is available in any one of your Accounts at any particular time will depend on the benefits you have elected.

- a. Premium benefit accounts are current in nature, and the District will pay out amounts you have set aside for insurance benefits as they become due for the respective coverages.
- b. If you elect Medical Expense Reimbursement benefits, your corresponding Benefit Account will be credited to reflect the amounts you have paid, although the full annual amount of the benefit will at all times be available to you (less previous benefits paid).
- c. If you have chosen to participate in the Dependent Care Expense Reimbursement Plan, your corresponding Benefit Account will be credited with the amount you set aside from each paycheck, and will accumulate until you submit a documented claim for reimbursement of eligible expenses.

**13. Who holds the funds I have set aside under the Plan?**

The money you set aside as payment for reimbursement of your eligible medical expenses or for reimbursement of your work-related dependent care expenses, will be segregated by the District into a separate fund as soon as is administratively possible after an amount has been deducted from your paycheck. Payroll deductions for insurance premiums will be forwarded monthly to the respective insurance companies as the premiums become payable.

**14. Will my Accounts earn any interest?**

No interest or other earnings will be credited to your Accounts at any time.

**15. How do I receive my benefits under the Plan?**

Insurance premium benefits will automatically be deducted each month from your appropriate Accounts (provided there are sufficient amounts credited to those Accounts to pay the required premiums. There always should be, since your salary reduction must equal the required premiums for optional benefits, less the available District-provided funds). The deducted amounts will be sent directly to the insurance companies for you.

If you have elected to participate in either the Medical Expense Reimbursement Plan or the Dependent Care Expense Reimbursement Plan, you will have to take certain steps to be reimbursed for your eligible expenses. When you incur an expense that is eligible for payment out of one of your Accounts, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. See Part II below for a description of the reimbursement procedures that apply to Medical and Dental Expenses, and Part III below for an explanation of the requirements for reimbursement under the Dependent Care Expense Reimbursement Plan. You may also use the debit card for reimbursement for eligible medical and dependent care expenses

You may not be reimbursed for any expenses with respect to your current year of participation that arise before the Plan became effective, your Enrollment Form becomes effective, or for any expense incurred after the close of the Plan Year excluding any grace period.

Please review the lists of eligible expenses for assistance in determining what is an "eligible expense." You are also encouraged to consult your personal tax advisor or IRS Publication #17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

To have your claims processed as soon as possible, please read the Claims Instructions you have been furnished. Note that it is necessary that you have actually paid an amount due for medical expenses or for dependent care expenses and that it is not being paid for by insurance or from any other source.

**16. When do I submit my claims?**

In order to be reimbursed, you must submit your Claim Form to the Plan's Administrator. In addition, you will have ninety (90) days after the end of the Plan Year together with any grace period in which to submit a claim for reimbursement for eligible expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

**17. What happens if my claim for benefits is denied?**

You will be notified in writing by the Plan's Administrator within ninety (90) days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within sixty (60) days of the date of your request for a review.

**18. Will unused year-end Account balances be carried over to the next Plan Year?**

Effective with the 2006 Plan Year, there is a grace period, which is an extension of the end of the Plan Year for a maximum of two and one-half (2 ½) months during which participants may incur additional expenses to use up their remaining unused benefits of contributions. Any unused amounts credited to your account as of the end of the Plan Year will be forfeited ninety (90) days after the end of the Plan Year together with the any grace period if you have not submitted a claim for eligible expenses incurred during the Plan Year. Hence, it is important for you to consider carefully how much of your salary or wages you desire to allocate to your Medical Reimbursement or Dependent Care account during a year.

**19. May I withdraw cash from any of my Accounts?**

No. Your Account balances may be used only to provide premium payment or expense reimbursement benefits, as the case may be.

**20. What is the debit card feature?**

The card allows you to access health and dependent care tax-advantaged funds at the time of service/purchase, eliminating the need to complete claim forms for reimbursement or eligible expenses. Generally your card can be used to pay for pharmacy prescriptions, certain over the counter health care items, dependent care expenses (if you have a dependent care FSA and the available funds in your account), and coinsurance, deductible or other out of pocket expenses for medical, dental and vision expenses.

**21. May I shift amounts from one Account to another?**

You may not transfer credits from one Account to another. For example, credits to your Medical Expense Reimbursement Account may only be used for that type of expense; no amount would be available for any other purpose.

**22. Can I stay in the plan if I am absent on a family medical leave?**

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA) during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. Of course, you must pay the premiums for the coverage during your absence.

You can continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid with pre-tax money as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid, you will have to reimburse the District at regular intervals from your after-tax funds for the premiums that come due during the leave.

**23. What if I am absent from work for duty in the uniformed services?**

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than thirty-one (31) days, your plan participation will be not interrupted. If the absence is for more than thirty-one (31) days and not more than twelve (12) weeks, you may continue to maintain your coverage under the plan by paying premiums with after-tax dollars.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than thirty-one (31) days, or if you revoke a prior election to continue to participate for up to twelve (12) weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the District's group major medical insurance plan (as described in Answer #26 below) for the 18-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

**24. What if I terminate my employment during the Plan Year?**

If your employment with the District is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan, other than as may be permitted under the Continuation Coverage provisions that apply to medical benefits elected under the Plan. (See Answer #26 for a description of Continuation Coverage.)

You will have until the ninetieth (90th) day after the last day of your participation in the Plan in which to submit a claim for eligible expenses incurred by you during the time you were covered under the Plan during the current Plan Year, up to and including the last day of the month in which your employment terminated. Reimbursements for pre-termination expenses will be limited to the balance of the contributions you made for medical expense reimbursement benefits before your employment terminated, reduced by any reimbursements you have already received during the Plan Year. Likewise, you will have no right to any portion of the annual benefit you elected that is left over as of the end of the Plan Year, regardless of how much you had contributed to the Plan.

**25. Will I have any administrative costs under the Plan?**

Yes. The monthly fee to participate in the plan is \$4.39.

**26. How long will the Plan remain in effect?**

Although the District expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. This Plan may be amended or terminated by a written resolution adopted by a majority of the Board of Trustees. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

**27. What is "Continuation Coverage" and how does it work?**

"Continuation Coverage" means your right, or your spouse and/or dependents' right, to continue to be covered under the Medical Expense Reimbursement Plan or under any of the medical insurance benefit plans described in Part IV, if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct) or reduction of your work hours below 20 per week;
- your death;
- divorce from your spouse;
- your becoming eligible to receive Medicare benefits; or
- when a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within sixty (60) days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you,

or your spouse as the case may be, with separate, written options to continue the coverages provided through this Plan at stated premium costs with respect to each health plan in which you are a participant. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

For most participants, there is no tax or other benefit to electing continuation coverage under the Medical Reimbursement Plan. If you elect COBRA continuation coverage, you will be required to contribute on an after-tax basis the amount you previously elected to contribute while an active employee. The tax benefit of the Medical Reimbursement Plan is lost when you make contributions on an after-tax basis.

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

**28. Can my participation in the Plan affect my employee benefits provided by the District or my benefit under the Teachers' Retirement System?**

When you make salary redirection contributions to the Plan with pre-tax dollars, you lower your taxable income. This does not, however, affect any of your other employee benefits that are based on the amount of your pay, such as your life insurance or disability insurance. Your salary redirection contributions will not affect the amount of your benefit you ultimately receive from the Teachers' Retirement System.

## **Part II**

### **Medical Expense Reimbursement Benefit**

One of the important features of your Employer's Flexible Benefit Plan is your opportunity to elect to receive income tax-free reimbursement for some or all of your uninsured medical and dental expenses under a related Medical Expense Reimbursement Plan. Under the Plan, you purchase a specific level of medical expense reimbursement benefits, paying for the coverage through a salary reduction agreement with the District, in lieu of a corresponding amount of current pay, which means the contributions you pay will be with pre-tax funds. This arrangement helps you because the benefits you elect are nontaxable, and you save income taxes on the amount of the contributions you pay.

#### **Questions and Answers**

##### **I. Who can participate in the Plan?**

Each employee of the District who is eligible to participate in the related Flexible Benefit Plan.

##### **2. How do I become a Participant?**

By electing Medical Expense Reimbursement Benefits during the Initial or annual Open Enrollment Periods.

##### **3. What is my "Medical Expense Reimbursement Account"?**

If you elect benefits under this Plan, a Medical Expense Reimbursement Account ("Account") will be set up in your name to keep a record of the benefits you are entitled to, as well as the contributions you have paid for such benefits during the Plan Year.

##### **4. What annual benefits are available under the Medical Expense Reimbursement Plan, and how much will they cost?**

You may choose any amount of annual benefit up to a maximum of \$5,000 for each Plan Year. You will be required to pay the amount of the annual contribution that corresponds to the benefit level you have chosen.

##### **5. How is my Medical Expense Reimbursement benefit paid for?**

When you complete the *Benefit Election Form*, you specify the amount you wish to elect for with your salary reduction. Thereafter, you must pay a contribution for such benefit

by having an equal portion of the total contribution deducted from each paycheck. Your employer actually funds the reimbursement benefits that may be payable to you. However, the full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket medical expenses at any time during the Plan Year, so long as you continue to pay the contributions.

For example, suppose you have elected to be reimbursed for up to \$1,000 per year for eligible medical expenses, and you have chosen no other benefits under the Flexible Benefit Plan: Your Account would be credited (and funded) with a total of \$1,000 during the Plan Year. Moreover, if you are paid semi-monthly, your account would reflect that you have paid \$41.67 per paycheck in contributions for the benefits you have elected.

**6. What amounts will be available for reimbursement benefits at any particular time during the Plan Year?**

Provided that you have continued to pay the periodic contributions due for this benefit, the full, annual amount of coverage you have elected will be available as a benefit at any time during the Plan Year, reduced by the amount of prior reimbursements received during the Year.

**7. How do I receive my benefits under the Plan?**

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your eligible expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a reimbursement form for the Medical Expense Reimbursement Benefit that will be supplied to you. You may also use the debit card for reimbursement for eligible medical expenses

If you have paid the contributions for the coverage you have elected, you will be reimbursed for your eligible expenses by the Plan's Administrator. Remember though, you can't be reimbursed for any total expenses above the annual amount of benefit you have elected.

To have your claims processed as soon as possible, please read the Claims Instructions you have been furnished. Please note that it is necessary that you have actually paid an amount due for an eligible medical or dental expense and that it is not being paid for or reimbursed from any other source. For purposes of the Plan, you are considered to have "incurred" an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill.

**8. What is an "eligible expense?"**

An "eligible expense" means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return for which you have not otherwise been reimbursed from insurance, or some other source.

Please review the list of eligible expenses included in Answer #9 below in determining

what is an "eligible expense." You are also encouraged to consult your personal tax advisor or IRS Publication #17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

## 9. What are Qualifying Health Care Expenses

Under the plan, you will be reimbursed only for those type of medical expenses generally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation) that are not reimbursed by any other source. They include, for example, expenses you have incurred for:

- Medicine, drugs, vaccines, and vitamins that your doctor prescribed.
- Over-the-counter drugs such as antacids, allergy medicine, pain relievers, and cold medicine purchased to alleviate or treat personal injuries or sickness.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrist, psychiatrists, psychologists, physical therapist, acupuncturists, and psychoanalysts (medical care only).
- Medical examination, X-ray and laboratory service, insulin treatment, and whirlpool baths the doctor prescribed.
- Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of nursing help.
- Hospital care (including meals and lodging), clinic cost, and lab fees.
- Medical treatment at a center for drug addicts or alcoholics.
- Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, and guide dogs and the cost of maintaining them.
- Ambulance service and other travel costs to get medical care. If you used your own car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim 9 cents a mile. Add parking and tolls to the amount you claim under either method.

You **cannot** obtain reimbursement for:

- The basic cost of Medicare insurance (Medicare A).
- Life insurance or income protection policies.
- The 1.45% hospital insurance benefits tax withheld from you as part of the Social Security tax or paid as part of Social Security self-employment tax.

- Nursing care for a healthy baby.
- Illegal operation or drugs.
- Over-the-counter drugs such as vitamins that are merely beneficial or for maintaining your general health.
- Cosmetic surgery (unless medically necessary).
- Travel your doctor told you to take to rest or change.

Qualifying medical expenses include only those expenses incurred for:

- Yourself.
- Your spouse.
- All dependents you list on your federal tax return.
- Any person that you could have listed as a dependent on your return if that person had not received \$2,000 or more gross income or had not filed a joint return.

***Note: IRS Publication 502, Expenses, has a checklist of medical expenses that can be deducted and therefore reimbursed under this plan and those that cannot.***

**10. When must the expenses be incurred that I may be reimbursed for?**

Eligible expenses must have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the plan became effective, before your Benefit Election becomes effective, or for any expenses incurred after the close of the Plan Year excluding any grace period. Unless Continuation Coverage is available and elected, no expenses incurred after employment termination may be reimbursed.

**11. What if the expenses I incur during the Plan Year are less than the annual benefit I have elected?**

You will not be entitled to receive any reimbursement that represents the difference between the actual expenses you have incurred during the Plan Year including any grace period for which you have been (or will be) reimbursed on the one hand, and the annual benefit you have elected and paid for, on the other.

## **Part III**

### **Dependent Care Expense Reimbursement Benefits**

Another major feature of your Employer's Flexible Benefit Plan, is your opportunity to elect to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under a related Dependent Care Expense Reimbursement Plan. Under the Plan, you provide a source of pre-tax funds to reimburse you for your eligible expenses by entering into a salary reduction arrangement with the District in lieu of a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable, you save income taxes on the amount of your salary reduction.

#### **Questions & Answers**

##### **1. Who can participate in the Plan?**

Each employee of the District who is eligible to participate in the related Flexible Benefit Plan.

##### **2. How do I become a Participant?**

By electing Dependent Care Expense Reimbursement benefits during the Initial or annual Open Enrollment Periods.

##### **3. What is my "Dependent Care Assistance Account?"**

If you elect benefits under this Plan, a Dependent Care Expense Reimbursement Account ("Account") will be set up in your name to keep a record of the benefits to which you are entitled.

##### **4. What are the maximum Dependent Care Expense Reimbursement benefits I may elect?**

You may elect up to \$5,000 per Plan Year if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care Expense Reimbursement benefit, your spouse maintained a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or
- are single or a head of household for tax purposes.

If you are married, reside together, but file a separate federal income tax return, the maximum benefit you may elect is \$2,500.

## **5. How is my Account funded?**

When you complete the *Benefit Election Form*, you specify the benefit amount for which you wish to pay with your salary reduction. Thereafter, your account will be credited with that portion of your gross income you have elected to forego through salary reduction. These portions will be credited as of each pay period.

For example, suppose you have elected to be reimbursed for \$2,400 per year for eligible dependent care expenses, and you have chosen no other benefits under the District's Flexible Benefit Plan: Your Account would be credited (and funded) with a total of \$2,400 during the Plan Year. Thus, if you are paid semi-monthly, you would have a total of \$100.00 credited to your Account each payday to pay benefits under this Plan. The amount that is available in your Account at any particular time will be that amount which has been credited to such Account less any reimbursements.

## **6. Who is an "eligible dependent" for whom I can claim a reimbursement?**

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is:

- under age thirteen (13) and for whom you could claim as a dependent on your federal income tax return;
- any other dependent who is mentally or physically unable of caring for himself or herself; or
- your spouse if physically or mentally incapacitated.

## **7. How do I receive my benefits under the Plan?**

There is a reimbursement form for the Dependant Care Expense Reimbursement Benefit. You will need to submit your reimbursement requests, with receipts for eligible expenses attached, to the Plan's Administrator, who will verify that the claims are eligible to be reimbursed. You may also use the debit card for reimbursement for eligible dependent care expenses.

Remember that you can't be reimbursed for any total expenses above your available annual credits to your Reimbursement Account. If the amount you actually paid for dependent care is for an amount that was more than your current account balance, the excess part of the claim will not be applied until the balance in the account can cover the expense.

You will not be reimbursed for any expenses that arise before your Enrollment Form

becomes effective, or for any expense incurred after the close of the Plan Year or after your discontinuation in the Plan.

Please review the list of eligible dependent care expenses included in Answer #8 in determining what is an "eligible expense." You are also encouraged to consult your personal tax advisor or IRS Publication #17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

Please note that it is necessary that you actually pay an amount due for eligible dependent care expenses and that it is not being paid for or reimbursed from any other source. Also note that you are not eligible to be reimbursed for amounts totaling more than the amount you have contributed to the Dependant Care Reimbursement Account, no matter what you may have paid.

## **8. Qualifying Dependent Care Expenses**

Under the plan, you will be reimbursed only for Dependent Care Expenses meeting all of the following conditions:

- The expenses are incurred for services rendered after the date of this election and during the plan year to which it applies.
- Each individual for whom you incur the expenses is an eligible dependent as defined in Answer #6.
- The expenses are incurred for the care of an eligible dependent or for related household services that enable you to be gainfully employed.
- If the expenses are incurred for services outside your household, they are incurred for the care of a dependent as described in #6 above or who regularly spends at least eight (8) hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The expenses are not paid or payable to a child of yours who is under 19 years of age at the end of the year in which the expenses are incurred.
- The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
- The reimbursement (when aggregated with all other reimbursements received by you under the plan during the Plan Year) may not exceed the least of the following limits:
  - the maximum amount allowed under the plan;

- \$5,000 if married filing a joint return, and \$2,500 if separate returns are filed;
- your taxable compensation (after all compensation redirection elections); or
- if you are married, your spouse's actual or deemed earned income.

Your spouse will be deemed to have earned income of \$200 (\$400 if you have two or more eligible dependents), for each month in which your spouse is (i) physically or mentally incapable of caring for him/herself, or (ii) a full time student at an educational institution.

**9. Will I be taxed on the Dependent Care benefits I receive?**

You will not normally be taxed on your Dependent Care Expense Reimbursement benefits, up to the limits set out in Answer #4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

**10. Are there any other limits on what Dependent Care Expense Reimbursement benefits are tax free?**

In addition to the dollar limitations discussed in Answer #4, the maximum amount of Dependent Care Expense Reimbursement benefits you may exclude from income during any calendar year cannot be more than:

- your earned income for the year if you are not married as of the end of the year, or
- the lesser of your earned income for the year, or your spouse's earned income if you are married at the end of the year. If your spouse is a full time student or is disabled, your spouse is considered under the federal tax rules as if he/she has a monthly earned income of \$200 (if Dependent Care benefits are provided for only one dependent) or \$400 (if Dependent Care reimbursements are made for two or more dependents).

**11. If I participate in the Dependent Care Expense Reimbursement benefit, will I still be able to claim the household and dependent care credit on my federal income tax return?**

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

**12. What is the household and dependent care credit?**

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Work-Related Dependent Care Expenses as a credit against your federal income tax liability under the U.S. Tax Code.

**13. When would I be better off to include the District's reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free, and forego the credit reimbursements under the Dependent Care Expense Reimbursement?**

Generally, if your income tax bracket is 15% or less, you will probably come out ahead by including the Dependent Care Expense Reimbursement benefit. On the other hand, it will generally be better to treat Dependent Care benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc., each Participant will have to determine his tax position individually in order to make the decision between taxable and tax-free benefits.

**14. If I participate in the Dependent Care Expense Reimbursement benefit, will I still be able to claim childcare expenses while on FMLA?**

No. Expenses incurred while on FMLA leave may not be claimed because those expenses were not incurred to allow you to continue work.

## **Part IV**

### **Insurance Premium Benefits**

Unless you elect not to participate, your portion of the premiums for certain health plans sponsored by the District will be made on a pre-tax basis. The plans sponsored by the District that are included in the pre-tax portion of the Plan are:

- Carrollton-Farmers Branch ISD's district sponsored medical plans
- Dental plans
- Vision plan

For the details regarding eligibility provisions, benefit amounts, and premium schedules, please refer to the plan summary of each separate benefit plan that is being furnished to you by the Plan Administrator.

## **Part VI**

### **Administrative Information**

#### **Plan Administrator**

Name	United Healthcare
Address	P O Box 981178
City, State Zip	El Paso, Texas 79998-1178
Telephone number	(877) 311-7849 Fax: (915) 781-1085

#### **District**

Name	Carrollton-Farmers Branch ISD
Address	1445 N. Perry Road
City, State Zip	Carrollton, TX 75006
Telephone number	972.968.6100
Federal ID number	75-6000328

#### **Plan Number**

The plan number assigned by the Plan Administrator is 710413.

#### **Agent for Service of Process**

District	Carrollton-Farmers Branch ISD
Address	1445 N. Perry Road
City, State Zip	Carrollton, TX 75006
Telephone number	972.968.6100