

SHARYLAND INDEPENDENT SCHOOL DISTRICT

**FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION**

EFFECTIVE MAY 1, 2015

PLAN PURPOSE

The Sharyland Independent School District Flexible Benefits Plan (the "Plan") is a benefit program that allows you to use pre-tax benefit dollars through payroll deduction to pay for insurance premium(s), unreimbursed medical expenses, and dependent care expenses. Section 125 of the Internal Revenue Code permits Sharyland Independent School District to offer you the opportunity to participate in designing your own personalized benefit plan on a tax-favored (pretax) basis. This Summary does not describe every detail of the Flexible Benefits Plan. If there is a conflict between the Plan Document and the Summary, the Plan Document will control.

WHO IS ELIGIBLE TO ENROLL IN THE PLAN

If you are an Employee regularly scheduled to work 30 or more hours per week for Sharyland Independent School District ("Employer"), or any affiliate of the Employer which adopts the Plan ("Participating Employer"), then you are eligible to participate in the Plan.

For purposes of the Premium Only Module your Spouse or Dependent(s) can only receive benefits through the Plan if they are named on your qualifying policy. Your Spouse or Dependent(s) cannot participate in the Plan independently.

Self-employed individuals are not eligible to participate in the Plan, however C Corporation owners who are also W2 Employees can participate.

HOW TO ENROLL

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made during the month preceding the Plan Year for which it will be in effect. Each year, Sharyland Independent School District will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your salary reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible Employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent permissible (your normal paycheck will not be voluntarily reduced). If you are already a Plan participant and you fail to complete an election form for the upcoming Plan Year, then you will be able to maintain the medical and dental benefit options, if any, that you elected for the prior year, but will not be eligible to participate in either the Health FSA or the Dependent Care Assistance Plan (DCAP) Spending Account.

You may build a completely new plan each year. Keep in mind that your choices are in effect for the entire Plan Year. Generally, you cannot change the elections you have made after the beginning of the Plan Year.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax payment of premiums until the next Plan Year.

WHEN YOU ARE ELIGIBLE TO ENROLL

You may enroll in the Plan effective on the first day of the month following one day of employment as an Eligible Employee.

SCHEDULE OF FLEXIBLE BENEFITS

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the Spending Accounts are provided by Sharyland Independent School District.

The benefits from which you may choose include:

- medical plan(s) outlined in Schedule A
- two different spending accounts:
 - a Health Flexible Spending Account (Health FSA)
 - a Dependent Care Assistance Plan Flexible Spending Account (DCAP)

Each benefit under the Flexible Benefits Plan has separate rules governing benefits and plan administration. These rules are explained in more detail in the plan documents that have been prepared solely for the purpose of each particular benefit. A copy of all this information is available from the HR Department at Sharyland Independent School District.

OPTIONAL BENEFITS

Briefly, the Optional Benefits from which you may choose are as follows:

1. Health Insurance Plans

You may purchase the health insurance coverage for yourself and your family through the Flexible Benefits Plan. You may pay for this coverage using pretax dollars that are automatically deducted per pay period. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

2. Flexible Spending Accounts (FSAs)

There are some expenses you know you will have to pay for in the coming year; for instance, new eyeglasses, medical and dental care expenses not covered by the health plan, or perhaps care for a child or an incapacitated dependent adult while you are at work. Normally you would pay for expenses like these with after-tax income. And, because taxes reduce the value of your dollar, you would have to earn considerably more than \$100 to pay for \$100 of expenses.

If you are eligible to participate, the Sharyland Independent School District Flexible Benefits Plan allows you to contribute pretax income to create special accounts in order to reimburse yourself on a pretax basis for payment of certain medical and dependent care expenses. It is like getting a discount on these bills since you do not have to earn as much money to pay for them. The money you contribute to spending accounts by automatic payroll deduction is not subject to federal or Social Security taxes but, depending on your residence, may be subject to state and local income taxes.

How Health FSAs and Dependent Care Assistance Plan Spending Accounts Work

You may establish spending accounts for two separate categories of predictable expenses - medical care and dependent care. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pretax pay, deposited on a per pay period basis to the spending account you have elected. The maximum pretax deferral for the Health FSA and for the Dependent Care Assistance Plan is outlined in Schedule B attached to this Summary. The Internal Revenue Code Section 125 states that these balances cannot be combined or used for purposes other than for which they were originally intended.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the Benefits Administrator of Sharyland Independent School District or the designated claims administration representative. Once the claims administrator receives the claims, all claims will be processed

for reimbursement on a weekly basis. Upon submission of a claim to your Health FSA, you will be reimbursed the full amount of your eligible expenses up to your elected Health FSA pretax deferral amount. However, you must have accumulated a sufficient credit balance in your Dependent Care Assistance Plan in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent months as more dollars are contributed from your pay to your Dependent Care Assistance Plan. If the Health FSA and/or Dependent Care Assistance Plan is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), you will be required to comply with substantiation procedures established by your Plan Administrator in accordance with IRS guidance. You must acquire and retain sufficient documentation to substantiate any expense paid with the debit card.

The Health FSA

Under this category are expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary", with substantiated claims and allowable as deductions under Code Section 213. Covered expenses do not include premiums paid for other health plan coverage, including plans maintained by the Employer of your Spouse or Dependents, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage. More detailed information about what is eligible and what is not eligible for reimbursement will be provided later in this Summary.

Reimbursable "Medical Care Expenses" will vary depending on which Health FSA coverage option you elect. If you have contributions to a Health Savings Account (HSA) during the year, you are only permitted to elect a Limited Health FSA, reimbursing dental, vision and preventive care and post deductible expenses, as outlined below. The following three options outline the definition of "Medical Care Expenses" as they relate to the General Purpose, Limited, and Employee Only Health FSA plans:

- **General-Purpose Health FSA Option.** For purposes of this Option, "Medical Care Expenses" means expenses incurred by you or your Spouse or Dependents for medical care, as defined in Code § 213(d) - provided, however, that this term does not include expenses that are excluded, nor any expenses for which you or other person incurring the expense is reimbursed for the expense through the Medical Insurance Plan, other insurance, a Health Savings Account (HSA), or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.
- **Limited Purpose Health FSA Option and Post Deductible Health FSA Option.** These are the only Health FSA options available to Employees funding a Health Savings Account (HSA). The Limited Purpose FSA Option defines "Medical Care Expenses" as those expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d) - provided, however, that such expenses are limited to vision care; dental care; and preventive care only. The Post Deductible FSA Option defines "Medical Care Expenses" as those expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d)-provided, however the expenses have been incurred after the minimum deductible for a qualified HSA insurance plan deductible has been satisfied. The minimum deductibles may change from year to year. Your Plan Administrator can advise you on what the minimum deductibles are. It is specifically the Employee's responsibility regarding Flexible Spending Account (FSA) reimbursements not to request anything that could violate the terms of the Employee's Health Savings Account (HSA).
- **Employee-Only Health FSA Option.** For purposes of this Option, "Medical Care Expenses" means expenses incurred by you (but not by your Dependent or Spouse) for medical care as defined in Code § 213(d) - provided, however, that this term does not include

expenses that are excluded, nor any expenses for which you are reimbursed through the Medical Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of Section 6 of the Health FSA Plan.

You must determine before the Plan Year starts which plan you elect and how much you will likely spend in out-of-pocket medical expenses. One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

The Dependent Care Assistance Plan Spending Account

Dependents are defined for this purpose as children up to age 13, handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return. If dependent care is required to enable you (or a Spouse or single person) to work, these expenses may be eligible for reimbursement. Included are payments to child care centers, nursery schools and payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a nonrelative, as long as such a person is reporting payments as income, is also eligible.

Be aware that you may be able to take a federal tax credit for eligible expenses up to \$3,000 (for one dependent) or \$6,000 (for more than one dependent). The credit equals 35% of expenses, reduced by one percentage point (but not to drop below 20%) for each \$2,000 (or fraction) by which your adjusted gross income exceeds \$15,000. Any amounts deferred to a Dependent Care Spending Account will reduce dollar-for-dollar the maximum allowable expense under the tax credit. This can be confusing, you may want to consult with your tax advisor, or see IRS Publication No. 503 "Child and Dependent Care Expenses".

Spending Accounts - Other Facts to Consider

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

- Compensation redirection authorized for medical and dependent care expense reimbursement is in effect for the entire year unless you have a change in status such as those listed under "Election Changes" in this Summary Plan Description.
- You must use all of the funds in your spending accounts by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses. However, your Employer may amend the Health FSA to adopt a 2 ½ month grace period allowing an expense incurred in a new Plan Year to be reimbursed from unused funds of the prior Plan Year. Or, your Employer may amend the Health FSA Plan to permit up to \$500.00 of unused funds from a prior Plan Year to carryover to the next Plan Year. These options only apply to the Health FSA component of your Plan. Your Employer will notify you of any such benefit before the end of the Plan Year to which it applies.
- You may request statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited. You may continue to submit claims up to 90 days after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given 90 days from their date of termination in which to submit expenses incurred prior to their termination for remaining Health FSA and Dependent Care FSA benefits.

ELECTION CHANGES

You generally cannot change your election to participate in this Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but that will apply only for the upcoming Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule, known as "Change in Election Events". Participants can change their elections under the Salary Reduction Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Changes in Election Event: Leaves of absence, including FMLA leave; Changes in Status; Certain Judgments, Decrees, and Orders; Medicare and Medicaid; Changes in Cost; and Changes in Coverage. Note that the Change in Election Events do not apply for all Benefits - applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence. A special HIPAA enrollment period of no more than 60 days is provided as of April 1, 2009 for Employees and their Dependents for loss of Medicaid or CHIP coverage; or upon becoming eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA and/or Dependent Care FSA enrollment. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

1. Leaves of Absence. You may change an election under the Salary Reduction Plan upon FMLA, non-FMLA, and USERRA leaves of absence.

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

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment). "Spouse" means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code ("the Code");
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "Dependent" means your tax dependent under the Code;
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefits eligibility under a cafeteria plan (including this Salary Reduction Plan) or other Employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid; union to non-union; or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular Employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance).
- a change in your, your Spouse's or your Dependent's place of residence.

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

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age)*. But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute \$100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of \$700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take effect until you have contributed a total of \$700 for the year. In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** For accident and health benefits (applies to Medical Insurance Plan and the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Salary Reduction Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Salary Reduction Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

*IRS Notice 2010-38 states that the applicable Treasury Regulations have been amended retroactively to March 30, 2010, to include Change in Status events covering children under age 27 who do not otherwise qualify as dependent children, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

- **DCAP Benefits.** With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

4. Special Enrollment Rights. (Applies to Medical Insurance Benefits, but Not to Health FSA or DCAP Benefits.) In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Medical Insurance

Benefits. When a special enrollment right applies to your Medical Insurance Benefits, you may change your election under the Salary Reduction Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders. (Applies to Medical Insurance Benefits and Health FSA Benefits, but Not to DCAP Benefits.) If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Insurance Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. (Applies to Medical Insurance Benefits, to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.) If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan, and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Medical Insurance Benefits and/or Health FSA Benefits, as applicable). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under Medicaid. The 60 day special enrollment period applies to Insurance Plans only, not to Health FSA and/or Dependent Care Assistance FSA enrollment.

7. Eligibility for Premium Assistance Subsidy. Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act if you become eligible for a Premium Assistance Subsidy. The 60 day special enrollment period applies to Insurance Plans only, not to Health and/or Dependent Care Assistance FSA enrollment.

8. Change in Cost. (Applies to Medical Insurance Benefits, and to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.) If the cost charged to you for your Medical Insurance Benefits or DCAP benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefits package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefits package option provides similar coverage. (Note that, for purposes of this definition, (a) the Health FSA is not similar coverage with respect to the Medical Insurance Benefits; (b) an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and (c) coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.)

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

9. Change in Coverage. (Applies to Medical Insurance Benefits and DCAP Benefits, but Not to Health FSA Benefits.) You may also change your election if one of the following events occurs:

- **Significant Curtailment of Coverage.** If your Medical Insurance Benefits or DCAP benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefits package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Medical Insurance Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefits package option that provides similar coverage, elect similar coverage under the plan of your Spouse's

employer, or drop coverage but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

- **Addition or Significant Improvement of Salary Reduction Plan Option.** If the Salary Reduction Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- **Loss of Other Group Health Coverage.** You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs). Effective April 1, 2009 you are provided a 60 day special enrollment period by the CHIP Reauthorization Act for you or your Dependent's loss of health coverage under CHIP. The 60 day special enrollment period applies to Insurance Plans only, not to DCAP enrollment.
- **Change in Election under Another Employer Plan.** You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.
For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Salary Reduction Plan to replace the dropped coverage.
- **DCAP Coverage Changes.** You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

10. Modifications Required by the Plan Administrator. The Plan Administrator may modify your election(s) downward during the Plan Year if you are a key Employee or highly compensated individual (as defined by the Code), if necessary to prevent the Salary Reduction Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you or such other person is properly entitled under the Salary Reduction Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

MEDICAL CARE EXPENSES THAT MAY BE REIMBURSED FROM THE HEALTH FSA

For Health FSAs, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" now

includes expenses for over-the-counter (OTC) drugs and medicines that are prescribed by a physician, as well as expenses for prescription drugs. Your Health FSA Account may reimburse reasonable quantities of over-the-counter (OTC) medical care items of the same kind purchased in a single calendar month; stockpiling is not permitted.

For more information about what items are and are not Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in the Publication are not correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA.) And not all expenses that are reimbursable under a Health FSA are deductible. (For example, Health FSAs may reimburse OTC drugs that are prescribed by a physician if they qualify as medical care under Code § 213(d), but they are still not deductible under Code §§ 213(a) and 213(b).)

Ask the Plan Administrator if you need further information about which expenses are (and are not) likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

FMLA LEAVES OF ABSENCE (Applicable to groups of 50+ employees)

If you go on a qualifying leave under the Federal Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Medical Insurance Benefits and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis). If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Medical Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Medical Insurance Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to. If your Medical Insurance Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before

the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave. If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

NON-FMLA LEAVES OF ABSENCE

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

ABOUT TAXES

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through the Flexible Benefits Plan may offset any possible reduction in Social Security benefits.

FUTURE OF THE FLEXIBLE BENEFITS PLAN

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

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

MATERNITY AND NEWBORN COVERAGE

Since this Plan could offer maternity and newborn coverage under the Health FSA and one or more of the Health Insurance Plan(s), you are advised that under Federal law, this Plan and the insurers may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods.

REVISED DEFINITION OF "DEPENDENT" BY WFTRA

The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA), effective January 1, 2005. An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

1. The individual has a specific family type relationship to the taxpayer
2. The individual does not provide more than half of his or her own support
3. The individual has the same place of residence as the taxpayer for more than half of the year
4. The individual does not turn age 19 (24 if a full-time student)*, by the end of the Plan Year

In addition, the following qualifying criteria apply to be a "dependent relative":

1. The individual has a specific family type relationship to the taxpayer
2. The individual is not a qualifying child of any other taxpayer
3. The individual receives more than half of his or her support from the taxpayer
4. The individual's annual gross income is less than the Section 151 limit (this criteria does not apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's Spouse are employed by Employer dependent children may be covered by either Spouse, but not by both.

*NOTE: the Internal Revenue Service (the "IRS") Notice 2010-38 (the "Notice") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year. Treasury regulations have been amended retroactively to March 30, 2010, to allow both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid by (or reimbursed to) the employee for such coverage to be excluded from the employee's gross income, in the same manner as coverage that is provided to an Employee's Spouse or Dependent defined under Section 152 of the Code. The Notice provides important guidance and further clarifications with regard to these issues.

YOUR PRIVACY RIGHTS UNDER HIPAA

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the Health FSA Plan from using or disclosing certain health information about you that is created or received by the Health FSA Plan without your written authorization. For additional information about your privacy rights, please either refer to the Plan's Privacy Notice or contact the Plan's Privacy Official.

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

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

The Plan may disclose to the Plan Administrator information on whether the individual is participating in the plan, or is enrolled in or has disenrolled from the Plan.

With respect to PHI disclosed by the Plan to the Plan Administrator, the Plan Administrator shall:

1. Not use or disclose the PHI other than is permitted or required by the Plan or by law.
2. Not use or disclose the PHI for employment-related actions and decisions.
3. Ensure that any agents, or subcontractors to whom PHI is provided, agrees to the same privacy restrictions and conditions that apply to the Employer and the Plan Administrator.
4. Report to The Plan any use or disclosure of PHI that is any violation of the HIPAA Privacy Rule.
5. Make available PHI to comply with the HIPAA right to access in accordance with the law.
6. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
7. Return or destroy all PHI received from the Plan that the Employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
8. Satisfy the requirement of adequate separation between the Plan and the Employer.

The Employer shall allow only the PHI Officer and other designated persons, access to PHI. These specified Employees, or classes of Employees, shall only have access to and use PHI to the extent necessary to perform the Flexible Benefits Plan administration functions that the Plan Administrator performs for the Plan. Any of these specified Employees who do not comply with the provisions of this Section, shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's Employee discipline and termination procedures.

COBRA CONTINUATION COVERAGE (Generally applicable to groups of 20+ employees)

If you terminate employment, under Federal law, you, your Spouse, and/or your covered Dependents lose coverage under this Plan. You, your Spouse, and/or your covered Dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more Employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an Employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" Employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

- (a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances.
- (b) Your Spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.
- (c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a Spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

"Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

Note: COBRA provides limited continuation coverage under the Health FSA and does not apply to Dependent Care Assistance Plans. A provision applies to balances remaining in these accounts through the date of termination, provided a claim is submitted within 90 days of the date of termination of employment.

COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The information furnished herein constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished. Note: Dependent care assistance plans and health savings accounts are not covered under the Employee Retirement Income Security Act (ERISA).

ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all Employer-sponsored group benefit programs conform to standards set by Congress. An Employee who is a Participant in the Health FSA is entitled to certain rights and protections under ERISA (Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA), however, for administrative convenience, this DCAP uses similar procedures for administration of DCAP claims), which provides that all Participants will be entitled to: (1) examine, without charge, at the Plan Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, such as copies of the latest annual reports (Form 5500), if any, and Plan descriptions; (2) obtain copies, upon written request to the Plan Administrator copies of all Plan documents and other Plan information governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report. Plan records are kept on a Plan Year basis.

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

Under ERISA, there are steps the Employee covered under the Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to \$110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Employee covered under the Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If the claimant is successful, the court may order the person sued to pay these costs and fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the

Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. Your specific rights to benefits under the plan are governed solely, and in every respect, by the Sharyland Independent School District Health FSA Plan Document, a copy of which is available from Sharyland Independent School District upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.

NOT A CONTRACT OF EMPLOYMENT

No provision of the Plan is to be considered a contract of employment between you and Sharyland Independent School District or a Participating Employer. Sharyland Independent School District's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

PLAN DEFINITION AND FUNDING

This is a Section 125 flexible benefits plan classified as a "cafeteria" plan by the Internal Revenue Code. It includes a Section 105 Health Flexible Spending Account, classified by the Department of Labor as a "welfare" plan, and a Section 129 Dependent Care Flexible Spending Account. The Plan is funded by Employee contributions.

GENERAL INFORMATION

Name: Sharyland Independent School District Flexible Benefits Plan
Plan Number: 510
Effective Date: May 1, 2015
Plan Year: May 1 to April 30

Type of Plans

- Section 125 Premium Only Plan
- Health Flexible Spending Account
- Dependent Care Assistance Plan Flexible Spending Account

Participants

The plan provides benefits for all Employees of Sharyland Independent School District and any Participating Employers who meet the eligibility requirements described herein.

Employer/Plan Sponsor Information

Sharyland Independent School District
1106 North Shary Road
Mission, TX 78572
Phone: 956-580-5200

Employer Identification Number (EIN): 74-6001658

Plan Administrator Information

Sharyland Independent School District
1106 North Shary Road
Mission, TX 78572
Phone: 956-580-5200

Named Fiduciary and Agent for Service of Legal Process

Sharyland Independent School District
1106 North Shary Road
Mission, TX 78572

SHARYLAND INDEPENDENT SCHOOL DISTRICT

FLEXIBLE BENEFITS PLAN

QUESTIONS AND ANSWERS

INTRODUCTION

As part of our efforts to keep your medical benefit costs as affordable as possible, Sharyland Independent School District (referred to in these questions and answers as the "Company") is pleased to sponsor the Sharyland Independent School District Flexible Benefits Plan (the "Plan").

The Plan provides each Eligible Employee with the opportunity to set aside part of his or her pay on a pre-tax basis to:

1. pay for his or her share of health insurance premiums under the health care program(s) sponsored by the Company;
2. provide for reimbursement of unreimbursed medical and dental expenses on a tax-free basis; and,
3. provide for reimbursement of eligible dependent care expenses you may incur as a result of work.

The Plan helps you because the benefits you elect are nontaxable. In addition, you save Social Security and income taxes on the amount of your salary reduction used to pay for these expenses.

Following are commonly asked questions and answers describing the basic features of the Plan and how it operates. Please review these questions and answers carefully, and do not hesitate to ask questions. This is your benefit, and it is important that you understand how it works and how it can help you. However, you should note that the questions and answers address only the key parts of the Plan. Consult the Plan documents or summary plan description for more details. Or, contact Sharyland Independent School District.

QUESTIONS & ANSWERS

1. What is the purpose of the Plan?

The purpose of the Plan is to permit Eligible Employees to elect to defer part of their pay on a pre-tax basis to defray their health insurance expenses, unreimbursed medical expenses and dependent care expenses.

2. What benefits are offered through the Plan?

Three kinds of benefits are offered under the Plan: a "Premium Only Plan", a "Health FSA Benefit", and a "Dependent Care Assistance Plan (DCAP) Spending Account". These benefits are explained in more detail below.

3. Who may participate in the Plan?

If you regularly work 30 or more hours per week with the Company or with any affiliated company that has adopted the Plan, you are eligible to participate in the Plan after the completion of one day of active employment with the Company. Only C Corporation Owners may participate in the Plan. Sole Proprietors, more than 2% owners of S Corporations and family members, Partners, and LLC owners are specifically excluded from participating by IRS Code.

4. What is the Premium Only Plan Benefit?

The Premium Only Plan allows you to pay your share of the health insurance premiums and other ancillary benefits with pre-tax dollars. If you do not elect to receive pre-tax benefits under the Premium Only Plan, you still will have to pay your share of the health insurance premiums under the Company's health care program(s), but on an after-tax basis. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

5. How does the Health FSA Benefit help me?

It is likely that you will have some medical expenses that you will have to pay for in the coming year. For example, you or your family may have medical expenses that are subject to deductible or co-payment limits under the Company's health plan. Or you may incur expenses that are not reimbursed at all. Normally, you would pay for these expenses with after-tax income. And, because taxes reduce the value of a dollar, you would have to earn considerably more than \$100 to pay for \$100 of expenses.

The Health FSA Benefit under the Plan permits Eligible Employees to contribute pre-tax income to a Health FSA on your behalf. The Health FSA will reimburse you on a pre-tax basis for your unreimbursed medical expenses. It's like getting a discount on these bills so you don't have to earn as much to pay for them.

6. How does the Health FSA Benefit work?

Once you have determined your annual predictable medical expenses for the plan year (or part thereof, if you first become eligible to participate in the middle of a plan year), you may elect to defer a portion of your salary into a Health FSA maintained on your behalf. You should take into account your health insurance deductibles and copayments, as well as uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be "medically necessary" as covered under Section 213 of the IRS code. Do not take into account premiums paid for health insurance coverage provided by the Company (since this is covered under the Premium Only Plan).

Also, do not take into account other health insurance coverage, such as that of your Spouse, or expenses for cosmetic surgery.

7. How much may I contribute to my Health FSA?

The maximum amount you may elect to defer into a Health FSA for a year is outlined in Schedule B attached to this Summary.

8. What is an "eligible expense" under the Health FSA?

An "eligible expense" means any items for which you can claim a medical expense covered under the Code Section 213 (with some limitations, see the Summary Plan Description for complete details) of the IRS. It is an expense for which you have not otherwise been reimbursed from insurance or some other source. Employees who have contributions to a Health Savings Account (HSA) during the year, must use their Health Flexible Spending Account (FSA) as a Limited Purpose FSA or a Post Deductible FSA only.

Please review the list of eligible medical expenses provided in your Sharyland Independent School District Summary Plan Description for assistance in determining what is an "eligible expense".

9. How do I receive medical expense reimbursements under the Plan?

To receive reimbursement, you must complete a claim form and attach any other information as the Plan Administrator may require. The Plan Administrator will instruct you as to how to file the form. When the claim is approved, you will be reimbursed the full amount of your eligible expenses, up to your elected Health FSA limit.

10. What happens to the money in my Spending Account(s) should I terminate?

You may submit claims on expenses incurred before the date of your termination, up until 90 days after you leave. If applicable, you may elect continuation coverage through COBRA and you may continue to use your Health FSA.

11. How long do I have after the Plan Year ends to submit my claims?

You will have 90 days after the Plan Year ends to submit claims on expenses incurred in that Plan Year, unless you terminate your employment from Sharyland Independent School District. A terminated Employee has 90 days from their date of termination to submit claims incurred in that Plan Year, but prior to their date of termination.

12. What else should I know about the Health FSA Benefit?

The IRS imposes certain restrictions on Health FSAs and DCAPs, including the following:

- Authorized salary reductions into your Health FSA and DCAP may not be changed for the rest of the year unless you terminate employment or have a change in status. Changes in status are discussed in detail in the Summary Plan Description.
- Generally, you will forfeit all unused funds in your Health FSA at the end of the year. This is the "use it or lose it" rule. Unused balances may not be carried over to the next year or converted to cash. For this reason, you should estimate your anticipated medical expenses for the year conservatively. Notwithstanding the above, your Employer might adopt up to a 2 ½ month grace period allowing an expense incurred in the new Plan Year to be reimbursed from unused funds of the prior Plan Year, or your Employer may amend the Plan to permit a carryover of up to \$500.00 of a Participant's unused FSA account balance to the following Plan Year. The Employer may adopt either the 2 ½ month Grace Period option or the FSA Carryover option, but not both, and will inform Participants of such benefit before the end of the Plan Year to which it applies.
- You may request periodic statements to remind you how much money is left in your Health FSA and DCAP. As indicated above, these amounts must be used by the end of the year or they will be lost, unless your Employer has adopted a Grace Period, allowing additional time to incur expenses that are reimbursed from the prior Plan Year unused account balances. Claims may be submitted up to 90 days after the end of the plan year in which the expenses were incurred. If you terminate employment, you may submit claims up to 90 days after you terminate employment.

13. What is the maximum amount of salary I can deposit per pay period to a Dependent Care Assistance Plan (DCAP) Spending Account?

The maximum you may deposit to a DCAP Account is \$5,000 per year. If you are married and file separately the maximum amount is \$2,500 per year.

14. How often will claims be paid under the DCAP?

Claims will be paid each week after you submit them, up to the balance of your account. Portions of your approved but unreimbursed expenses will be paid monthly as your account rebuilds.

15. Who is an "Eligible Dependent" for whom I can claim a reimbursement under the Dependent Care Spending Account?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13 whom you could claim as a dependent on your federal income tax return; any other dependent who is mentally or physically unable to care for himself or herself; or your Spouse, if he or she is physically or mentally incapacitated. See the section titled 'Revised Definition of "Dependent" by WFTRA' in this Summary for more information on the definition of Dependents.

To have your claims processed as soon as possible, please read the Claims Instructions you have been furnished. Please note that it is not necessary that you have actually paid the amount due for an Eligible Dependent Care Expense - only that you have incurred the expense and that it is not being paid by or being reimbursed from any other source.

16. Will I be taxed on the Dependent Care Assistance Plan benefits I receive?

You will not normally be taxed on your Dependent Care benefits, up to your DCAP Account deferral amount. 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.

17. If I participate in the DCAP 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. However, the balance of your dependent care expenses not eligible for reimbursement under this Plan, if any, may be eligible for the dependent care credit.

18. 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 Internal Revenue Code. In determining what the tax credit would be, you may take into account only \$3,000 of such expenses for one dependent, or \$6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit of \$1,050 for one dependent or \$2,100 for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of \$600 for one dependent or \$1,200 for two or more dependents). The maximum 35% rate must be reduced by 1% (but not below 20%), for each \$2,000 (or any fraction of \$2,000), of your adjusted gross income over \$15,000. If this is too confusing, consult with your tax advisor, or see IRS Publication No. 503 "Child and Dependent Care Expenses".

19. Are my Plan benefits taxable?

Under current law, the benefits you receive under the Plan are not currently taxable to you, nor are the benefits subject to federal income tax withholding and Social Security (FICA) withholding taxes.

20. Will the Health FSA claims I submit to my plan administrator be kept private?

Yes, HIPAA Rules require that Protected Health Information (PHI) given to the plan administrator be kept completely confidential. See the Summary Plan Description for the complete Privacy Statement regarding PHI.

21. How does the Plan save me money?

The following example illustrates how the Plan saves you money. Assume that your monthly share of the health insurance premium is \$400 per month, your monthly income is \$4,000, and you are in the 28-percent federal income tax bracket and the 7.5-percent state tax bracket. Assume also that you expect to have \$2,400 in uninsured medical expenses during the year. If you pay your health insurance premiums using the Premium Only Plan and your uninsured medical expenses using the Health FSA Benefit, you will save approximately \$259 per month, or \$3,107 per year. These amounts are computed as follows:

	<i>with</i>	<i>without</i>
	Pre-Tax Health FSA & Pre-Tax Health Insurance	Pre-Tax Health FSA & Pre-Tax Health Insurance
Monthly Salary	\$4,000.00	\$4,000.00
Health Insurance Premium	(\$400.00)	\$0.00
Uninsured Medical Expenses	(\$200.00)	\$0.00
Taxable Income	\$3,400.00	\$4,000.00
Federal Income Tax (28%)	(\$952.00)	(\$1,120.00)
State Income Tax (7.5%)	(\$255.00)	(\$300.00)
Social Security / FICA (7.65%)	(\$260.10)	(\$306.00)
Health Insurance Premium	\$0.00	(\$400.00)
Uninsured Medical Expenses	\$0.00	(\$200.00)
Net Take Home Pay	\$1,932.90	\$1,674.00
Monthly Tax Savings	\$258.90	
Annual Tax Savings	\$3,106.80	

22. When and how do I elect the Plan benefits?

You will be provided a form when you first become eligible to participate. This form will notify you of your eligibility for participation in the Plan, upon which you may elect the Premium Only Plan, Health Savings Account contributions, Health FSA Benefit and/or the DCAP. If you elect the Premium Only Plan, the health insurance premiums you are already making will be converted to a pre-tax basis.

In future years, you will be furnished a new form by the first day of the annual enrollment period and be given the opportunity to confirm or change your existing choices for the coming calendar year.

23. The Plan sounds too good to be true. Are there any reasons why I shouldn't participate?

As discussed above, the salary you elect to use to pay for Plan benefits is free from income and FICA taxes. This is a valuable benefit. However, because amounts deferred under the Plan are not counted as wages when determining your Social Security benefit, it is possible that there may be a reduction in your Social Security benefits. If your salary is above the Social Security Taxable Wage Base you probably will not be affected. If your salary is below the Social Security Taxable Wage Base, your Social Security benefits might be reduced. You should consult your own financial or tax advisor to determine the effects of electing to participate in the Plan.

24. Can I change my election during the Plan Year?

Generally, you may not change or vary your elections during the Plan Year. However, you may change your elections during the annual enrollment period for the coming Plan Year. The Plan Administrator will advise you when you may elect to change your elections for the upcoming plan year.

There is an important exception to this general rule: You may change or revoke your election at any time during the Plan Year if you have a qualifying change in status (which generally includes a change in your legal marital status or change in the number of dependents). See the qualifying changes in status listed under "Election Changes" in this Summary.

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

The insurance companies providing the benefits under the Plan will receive all amounts withheld from your paycheck for payment of premiums. Amounts contributed under the Health FSA and DCAP benefits will be retained by the Company but earmarked to pay for Health FSA and DCAP Benefits. Separate bookkeeping entries will be maintained to keep track of your Health FSA and DCAP Benefits.

26. When will my participation in the Plan cease?

If you elect to participate in the Plan, your participation will continue until you separate from service with the Company or elect to stop making contributions under the Plan. Also, with respect to this Plan, if your employment status changes so that you regularly work less than 30 hours per week, your participation in the Plan will cease. However, you may be eligible for continuation coverage under this Plan.

27. What is continuation coverage?

If you, your Spouse, and/or your covered Dependents lose coverage under this Plan, you may be entitled to COBRA continuation of health care coverage, including the Health FSA. Generally, if the Employer has employed twenty (20) or more Employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a specific period of time. The Administrator will inform you of these rights if you lose coverage and you are entitled to continuation coverage.

The Dependent Care Assistance Plan provides a period entitling you to claim reimbursement for any qualifying Dependent Care Expenses incurred before employment termination. Qualifying Dependent Care Assistance expense claims must be filed within 90 days after the date of termination.

28. Will I have any administrative costs under the Plan?

No. The Company will pay the entire cost of administering the Plan.

29. How long will the Plan remain in effect?

The Company has the right to modify or terminate the program at any time, or to elect not to continue sponsorship of the Plan.

30. What happens if my claim for benefits is denied?

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the Health FSA are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Plan Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If

you do not submit the additional information, the Administrator will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Health FSA's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to appeal the Plan Administrator's denial of your claim.

D. What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

E. Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission.

If you do not file your appeal within this 180-day period, you lose your right to appeal.

Your appeal will be heard and decided by the Committee.

F. How will my appeal be reviewed?

Anytime before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Committee. The Health FSA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Health FSA who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

G. When will I be notified of the decision on my appeal?

The Committee must notify you of the decision on your appeal within 60 days after receipt of your request for review.

H. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Committee will include the following information:

- The specific reason for the denial upon review;
- A reference to the specific Health FSA provision(s) on which the denial is based;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring a civil action under ERISA § 502(a).

No action may be brought against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Plan Administrator.

31. Can I request an external review if my appeal is denied?

If the Health FSA is an excepted benefit, it is not subject to external review requirements. To be an excepted benefit, the Health FSA must satisfy two conditions:

- A. Maximum Benefit Condition.** The maximum benefit payable under the Health FSA to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the Health FSA for the year (or, if greater, the amount of the participant's salary reduction election for the Health FSA for the year, plus \$500).
- B. Availability Condition.** Other nonexcepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment.

If the Health FSA is not an excepted benefit, it is subject to external review requirements. If the denial of your claim is not related to your (or your beneficiary's) failure to meet the requirements for eligibility under the terms of your Employer's HRA, you may be eligible to request an external review. View current procedures and timeline relevant to the external review request at <http://www.dol.gov/ebsa> or call the Employee Benefits Security Administration, 866-444 EBSA (3272).

SHARYLAND INDEPENDENT SCHOOL DISTRICT

SCHEDULE A

MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN*:

OFFERED	NAME OF COVERAGE
<input checked="" type="checkbox"/>	Group Health Insurance
<input checked="" type="checkbox"/>	Group Dental Insurance
<input checked="" type="checkbox"/>	Vision Care Insurance
<input checked="" type="checkbox"/>	Group Term Life Insurance (Employee Only)
<input checked="" type="checkbox"/>	Disability Income-Short Term (A&S)
<input checked="" type="checkbox"/>	Disability Income-Long Term (LTD)
<input checked="" type="checkbox"/>	Cancer Insurance
<input checked="" type="checkbox"/>	Accidental Death & Dismemberment
<input checked="" type="checkbox"/>	Critical Illness Insurance
<input type="checkbox"/>	Heart & Stroke Insurance
<input checked="" type="checkbox"/>	Accident Insurance
<input checked="" type="checkbox"/>	Hospital Indemnity Insurance

*The Employee contributions necessary to obtain the coverage options set forth in this Schedule A above will be communicated by the Employer to Eligible Employees at the time of Enrollment. The required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option above. It is specifically the Participant's responsibility regarding insurance premium reimbursement not to request anything that could violate the terms of their insurance policy.

SHARYLAND INDEPENDENT SCHOOL DISTRICT

SCHEDULE B

HEALTH FSA AND DEPENDENT CARE ASSISTANCE PLAN

EMPLOYEE CONTRIBUTION LIMITATIONS

	Minimum	Maximum
HEALTH FLEXIBLE SPENDING ACCOUNT <i>(Annual Amount)</i>	N/A	\$2,550.00
DEPENDENT CARE ASSISTANCE PLAN <i>(Annual Amount)</i>	N/A	\$5,000.00