ACTION ITEM

Date: April 23, 2019

To: Raymond E. Lechner, PhD, Superintendent

From: Heather Glowacki, EdD, Assistant Superintendent

Subject: Resolution to Restate the District 39 Section 125 Flexible Benefits Plan

PROPOSED ACTION BY THE BOARD OF EDUCATION

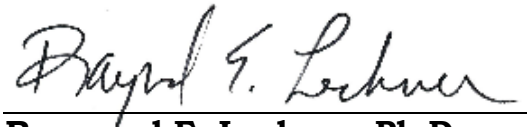
Motion to approve the attached resolution to restate the District 39 Section 125 Flexible Benefits Plan.

BACKGROUND

Since last updated in 2014, there have been several legal changes to the District 39 Section 125 Flexible Benefits Plan. The insurance plan year has changed from September 1- August 31 to June 1-May 31. Although the District adjusted its practices to match the new plan year, Section 125 Flexible Benefits Plan document needs to be amended to reflect the new plan year. This resolution would adjust the HRA plan year to be June 1- May 31. This resolution authorized District Administration to amend Section 125 Flexible Benefits Plan to comply with Internal Revenue Codes and any changed or modified benefit changes. This authority will ensure that the flexible benefits plan reflects current laws and practices governing the accounts specified in the plan. Examples of some accounts in Section 125 Flexible Benefits Plan include, Flexible Savings Accounts (FSA), Health Savings Account (HSA), Health Reimbursement Arrangements (HRA), and Dependent Care reimbursement.

HG/hg

Recommended for approval by the Board of Education



Raymond E. Lechner, Ph.D.
Superintendent of Schools

RESOLUTION
OF THE
BOARD OF EDUCATION OF
WILMETTE SCHOOL DISTRICT NO. 39
COOK COUNTY, ILLINOIS

RESTATING

THE WILMETTE PUBLIC SCHOOLS DISTRICT 39
SECTION 125 FLEXIBLE BENEFITS PLAN

WHEREAS, the Board of Education of Wilmette School District No. 39, Cook County, Illinois, (the "Board") currently offers the Wilmette Public School District No. 39 Section 125 Flexible Benefits Plan to its eligible employees; and

WHEREAS, Section 125 Flexible Benefits Plan currently in effect is dated September 1, 2014; and

WHEREAS, the Board desires to amend Section 125 Flexible Benefits Plan by fully restating the Plan on substantially the same terms, effective with the September 1, 2019, Section 125 Flexible Benefits Plan Year to ensure its status as a fully compliant plan; and

WHEREAS, a copy of Section 125 Flexible Benefits Plan is attached hereto as Exhibit A in substantial form; and

WHEREAS, the Board desires to provide District Administration with the authority to amend Section 125 Flexible Benefits Plan documents as needed for purposes of meeting the requirements of the *Internal Revenue Code* and applicable regulations and guidelines and to effectuate any changed or modified benefit options provided by the Board now and in the future.

NOW, THEREFORE, Be It Resolved by the Board of Education of Wilmette School District No. 39, Cook County, Illinois, that:

1. That Section 125 Flexible Benefits Plan be restated in full, effective September 1, 2019, in substantially the form presented in Exhibit A, subject to legal review, and that such Section 125 Flexible Benefits Plan is hereby adopted and approved, effective as of the date of adoption and retroactive as provided therein.

2. The Board hereby provides the Superintendent or designee with the authorization to modify Section 125 Flexible Benefits Plan now and in the future for purposes of meeting the requirements of the *Internal Revenue Code* and applicable regulations and guidelines to effectuate any changed or modified benefit options provided by the Board now and in the future.

IN WITNESS WHEREOF, the undersigned hereunto have executed this Resolution on this ___ day of _____, 2019.

ADOPTED this _____ day of _____, 2019, by the following vote:

AYES:

NAYS:

ABSENT:

_____
President, Board of Education
Wilmette School District No. 39
Cook County, Illinois

ATTEST:

_____
Secretary, Board of Education
Wilmette School District No. 39
Cook County, Illinois

EXHIBIT A

WILMETTE SCHOOL DISTRICT NO. 39

~~CAFETERIA~~/SECTION 125 FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

Amended May 22, 2014 – effective for Plan Year beginning September 1, 2014

WILMETTE SCHOOL DISTRICT NO. 39

~~CAFETERIA/~~SECTION 125 FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

The Board of Education of Wilmette School District No. 39 has established a ~~Cafeteria/~~ Section 125 Flexible Benefits Plan ("Plan") to provide reimbursement of certain medical/dental and dependent care expenses and to permit the payment of certain medical, dental, life, vision, and long-term disability premiums. The Plan's purpose is to reward employees by making these benefit choices available. The full ~~Cafeteria/~~Section 125 Flexible Benefits Plan is available for your review in the Business Office. Please read this Summary Plan Description carefully as we have amended the Plan this year to offer additional Benefit options. You should direct any questions you may have to the Administrator.

IMPORTANT INFORMATION

Effective Date:	July 1, 1989, as amended July 16, 2007, August 1 2008, April 1, 2009, and September 1, 2012, and May 22, 2014
Plan Year:	September 1 – August 31
Plan Name:	Wilmette School District No. 39 ~~Cafeteria/~~Section 125 Flexible Benefits Plan
Employer (Plan Sponsor):	The Board of Education of Wilmette School District No.39
Plan Administrator:	The Board of Education of Wilmette School District No.39

The Plan Administrator is designated as agent for all purposes of legal process.

CAFETERIA/SECTION 125 FLEXIBLE BENEFITS PLAN

The Wilmette School District No. 39, ~~Cafeteria/~~Section 125 Flexible Benefits Plan ("Plan") allows employees to choose among different types of benefits based on their own particular goals, objectives and needs, and select the level of benefit which best suits their own individual situations. The plan purpose is to reward employees by making these benefit choices available.

AM I ELIGIBILE?

You are eligible to join the Plan if you meet the eligibility requirements of one of the Benefit Election Forms ("Benefit Schedule/Election Forms), attached hereto and incorporated herein as well as the eligibility requirements of the Plan. Your available benefits may vary depending upon which Benefit Election Form applies to your employment as well as an individual employment contract that applies to you, an applicable collective bargaining agreement or the Compensation and Benefits for Administrators handbook if it applies, and your status of employment ("Eligibility Documents").

Subject to special enrollment rights under the *Health Insurance Portability and Accountability Act* ("HIPAA") and the *Children's Health Insurance Program Reauthorization Act of 2010* (CHIPRA), if you are eligible to participate, you will become a participant in the Plan on the later of: (a) the Effective Date of the Plan, or (b) the first day of the month following the date you elect to participate in the Plan.

WHAT ARE MY TAX ADVANTAGES?

One of the major advantages of the Plan is the potential for tax savings. The Plan provides each employee with the opportunity to allocate part of the employee's compensation on a pre-tax basis for the purchase of group health and dental insurance offered through the District, by method of a salary reduction agreement. As an employee, you may also allocate portions of your compensation in pre-tax dollars to special flexible spending accounts for reimbursement of eligible medical expenses and dependent care expenses (up to plan maximums and current IRS limits) as well as to other benefits either on a pre-tax or after-tax basis. You save Social Security and Income taxes on the amounts you allocate to elected benefits because your taxable compensation is reduced by the amounts you allocate. This could also result in a small reduction in the Social Security benefit you receive at retirement.

Eligibility for Pre-Tax Health Insurance Premium Savings

Eligibility for tax favored treatment of benefits is based upon federal *Internal Revenue Code* ("IRC") provisions and regulations, which include statutory definitions of terms such as qualifying "dependents" for purposes of tax-free insurance coverage. The *Illinois Insurance Code* prohibits the cessation of health insurance benefits to dependents based solely upon the dependent's age prior to age 26 or age 30 for certain military veterans. However, IRS interpretations of current law allow payment of premiums on a tax-free basis only for dependents up through age 26 who will not have reached age 27 by the end of a tax year. Because the Illinois requirement for coverage of dependents is broader than the IRC definition of "dependent" for tax-free insurance premium purposes (under the IRC definition of "qualifying child"), the cost of insurance for these older dependents may be taxable. If you are paying the premium, that portion of the premium attributable to a dependent who does not meet the age 26 standard cannot be paid for with pre-tax dollars. Likewise, if a portion of the premium is paid for by the District, then that portion of the premium attributable to such a dependent who does not meet the age 26 standard constitutes taxable income and must be reported on your W-2 and is subject to taxation.

The District's health insurance plan also allows domestic partners and civil union partners of employees to have coverage under the health plan. However, current federal law governing the operation of the Plan defines the term "spouse" for purposes of eligibility for benefits under this Plan as including someone united with the Plan Participant in a marriage as defined by Federal law. Illinois recognizes same sex marriages. Thus, if you are married under Illinois law whether to an opposite sex or same sex partner, federal law will allow benefits to be pre-tax for that partner. However, unless the domestic partner otherwise qualifies as a dependent (i.e. "qualifying relative") under the IRC for health insurance (pursuant to Sections 152, 106 and 105 of the IRC), payment of premiums for coverage under the District's health insurance plan cannot be made on a pre-tax basis for that domestic partner. If you have a civil union partner that you are not married to under Illinois law, the benefits under this plan for that partner are sheltered from Illinois state taxes by not federal.

Eligibility for Pre-Tax Medical Flexible Spending Reimbursements

Further, for purposes of the Medical Flexible Spending Plan and the Limited Purpose Medical Flexible Spending Plan, you can include medical expenses you paid for your dependent and spouse. For you to include these expenses, the person must have been your dependent either at the time the medical services were provided or at the time you paid the expenses. A person generally qualifies as your dependent for purposes of the medical expense reimbursement if he/she is (1) a dependent as defined in IRC Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; or (2) your child (as defined in IRC Section 152(f)(1)) who has not attained age 27, or (3) your child to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced parents). Special rules also apply for adopted dependents and those children covered by a qualified medical child support order ("QMCSO").

Eligibility for Participation in the Health Savings Account

Eligibility for participation in the HSA is determined by the terms of HSA documents and may be outlined in an HSA summary plan description.

WHAT IS THE PLAN YEAR?

The Plan Year begins on September 1 and ends on August 31.

The Plan has been established and is maintained in accordance with the IRS regulations and is subject to compliance with such regulations and amendments to the same.

WHAT ARE MY BENEFIT OPTIONS?

Under the Plan, you can choose to receive your entire compensation or use a portion of that compensation (up to $35,000 per Plan Year) to pay for any one or more of the following benefits or expenses during the Plan Year. Each Benefit option under the Plan has separate rules governing benefits and Plan administration. These rules are explained in more detail in the Plan document that has been prepared solely for the purpose of each particular benefit. A copy of this information is available from the District's Business Office. Eligibility and benefit amounts are further outlined in the Benefit Schedule/Election Forms attached hereto.

HEALTH INSURANCE

The District has made available several different plans of health insurance. There is an HMO and a PPO option. The PPO option is a High-Deductible Health Plan ("HDHP") option. All of

the insurance options may be used in unison with all other Benefit options offered under the Plan as those Benefit options are available except for the Health Savings Account ("HSA") and Limited-Purpose Medical Flexible Spending Plan ("Limited FSA"). Only employees choosing the HDHP health insurance option may participate in the HSA and Limited FSA. As further described below, pursuant to IRS rules, the HSA may only be used by participants in an HDHP who are not covered by any other health plan that is not an HDHP. However, the IRS does allow HSA participants to concurrently participate in a plan such as the Limited FSA. Which options and the level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

DENTAL INSURANCE

The District has made available two different types of dental insurance. The level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

IMRF GROUP TERM LIFE INSURANCE

The District has made available group term life insurance. This insurance may be offered as a pre-tax benefit (subject to a certain limit) because it qualifies as group term life insurance. Thus, premiums for this insurance may be paid through salary reduction before taxes, where allowed. The level of benefit and nontaxable nature available to you may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

Only qualified group term life insurance premiums for face amounts up to $50,000 can be paid for with pre-tax dollars. Premiums for additional insurance in excess of $50,000 (the difference between $50,000 and the face amount) are after-tax salary deductions.

AFTER-TAX TERM LIFE INSURANCE

This insurance is not offered as a pre-tax benefit because it does not qualify as group term life insurance. Thus, premiums for this insurance will be paid through salary reduction after taxes. The level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

VISION INSURANCE

The District has made available vision insurance. This insurance is offered as a pre-tax benefit. Thus, premiums for this insurance may be paid through salary reduction before taxes. The level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

LONG-TERM DISABILITY INSURANCE

The District has made available a policy of long-term disability insurance. Because this insurance does not provide for long-term care, it is offered as a pre-tax benefit. Thus, premiums for this insurance may be paid through salary reduction before taxes. This insurance provides income to you in the event you are unable to work and have exhausted all paid leave benefits. Premiums are based upon a percentage of your salary. The level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

MEDICAL FLEXIBLE SPENDING PLAN

The Medical Flexible Spending Plan or Medical Flexible Spending Account ("Medical FSA" or "FSA"), is an account to which you may allocate pre-tax dollars for the reimbursement of miscellaneous medical expenses incurred by you, your spouse, and/or your qualifying dependents. This account is to be utilized for out of pocket medical expenses not otherwise covered by insurance. Eligible expenses include, but are not limited to, deductible co-insurance amounts within the health-plan, dental and orthodontic expenses, and other medical expenses not covered by insurance. An illustrative listing is provided in this Summary Plan Description as well as in IRS publications available in the District office and online at www.irs.gov. Eligible expenses do not include premiums paid for health plan coverage.

The District has established a limit of $2,500 as the maximum amount you may allocate to this account in the Plan Years beginning after December 31, 2012.

DEPENDENT CARE ASSISTANCE FLEXIBLE SPENDING PLAN

The Dependent Care Assistance Flexible Spending Plan or Dependent Care Assistance Account ("Dependent FSA" or "FSA"), is an account to which you may allocate pre-tax dollars for the reimbursement of employment related dependent care expenses you incur during the applicable plan year.

> NOTE:The current tax law limits allocations in dependent care reimbursement assistance to $5,000 ($2,500 for married individuals filing separate returns). IRS publication 503 provides additional information on the eligibility of these expenses. IRS Publications 502 and 503 are intended for use when preparing a 1040 federal tax return, and are equally valid for determining the eligibility of expenses for reimbursement of claims.

You should note that in some situations, using the dependent care reimbursement account may provide a greater tax advantage than the 1040 tax credit. In other situations this may not be true. Employees requesting advice about which option to use are strongly urged to discuss their situation with their qualified tax advisor, who is familiar with their own situation.

LIMITED-PURPOSE MEDICAL FLEXIBLE SPENDING PLAN

The District has made available a Limited FSA for use by participants with a Health Savings Account. According to Section 223 of the *Internal Revenue Code* and various Treasury regulations, an individual may contribute to an HSA only while covered by a HDHP and not by any other health plan which is not an HDHP. Because the District's Medical Flexible Spending Plan is considered a non-HDHP, a participant in the District's Medical Flexible Spending Plan cannot contribute to an HSA. However, an HSA participant may contribute to an HSA even though he/she is covered by the Limited FSA. This Limited FSA only pays or reimburses

permitted coverage benefits described in IRS code Section 223, such as vision care, dental care or preventative care. The level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form for additional information.

The District has established a limit of $2,500 as the maximum amount you may allocate to this account in the Plan Years beginning after December 31, 2012.

HEALTH SAVINGS ACCOUNT

The District has made available a method for employees so choosing to contribute to a Health Savings Account ("HSA"). According to Section 223 of the *Internal Revenue Code* and various Treasury regulations, an individual may contribute to an HSA only while covered by a HDHP and must not be covered by any other health plan that is not an HDHP. Employees choosing to participate in the District's HDHP may also contribute to their HSA through the Plan via salary reduction. It is further established that the District may also make employer contributions to the HSA. The level of benefit offered may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form for additional information.

The District is authorized under the Plan to make Non-Elective Employer Contributions to the HSAs of Eligible Employees. The amount of this contribution may vary depending on your employee classification and whether or not you have full-time employment with the District. Please refer to the appropriate, attached Benefit Schedule/Election Form, Eligibility Documents, and the Plan document for additional information.

A NOTE ABOUT THE HEALTH REIMBURSEMENT ARRANGEMENT ("HRA") AND COORDINATION WITH THE MEDICAL FLEXIBLE SPENDING PLAN

The IRS sets forth certain rules with regard to the coordination of reimbursements for individuals who are participating in both a medical flexible spending plan and an HRA. Employees who are participants in an HRA who would also like to participate in any of the Medical Flexible Spending Accounts should consult the Plan documents for additional information regarding coordination of these benefits.

A NOTE ABOUT FLEXIBLE SPENDING ACCOUNTS AND HOW THEY WORK

Basically, you may establish Flexible Spending Accounts for two separate categories of predictable expenses – medical 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 basis to the spending account you have elected. Please note that medical and dependent care balances cannot be combined or used for purposes other than for which they were originally intended.

Other than qualifying the eligibility of an expense, few restrictions exist. However, the following general guidelines apply:

1. Expenses submitted for reimbursement must have been incurred during the Plan Year or the employee's period of coverage if less than the Plan Year. Expenses are treated as having been incurred when the participant receives the medical care that gives rise to the

expense, regardless of when the participant has been billed, formally charged, or has paid for the medical care.

2. You cannot "double dip." If the expense will be claimed as a deduction on your 1040 federal tax return, it cannot be submitted for reimbursement. In addition, if an insurance carrier has paid all or a portion of the claim, the portion paid by the insurance company cannot be submitted for reimbursement.

3. If you receive reimbursement for an ineligible expense through a Flexible Spending Account, any adverse tax consequence as the result of an IRS audit belongs to you.

4. A dependent for whom medical expenses are submitted for reimbursement must not reach age 27 in the tax year reimbursed unless such individual meets the definition of "qualifying child" or "qualifying relative" under the IRC and meets other requirements of such IRC sections.

5. You must use all of the funds in your Dependent Care Flexible Spending Account by the end of the Plan Year or you will lose them; the balances cannot be combined with the funds in the Medical Flexible Spending Account, carried over into the next year, or converted to cash. You must use all of the funds in your Medical Flexible Spending Account by the end of the each Plan Year or you will lose them. Again, these funds cannot be combined with the Dependent Care Flexible Spending Account, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Flexible Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses.

ARE THERE ANY SPECIFIC RESTRICTIONS ON MEDICAL FLEXIBLE SPENDING OR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS?

Medical Flexible Benefits

The Medical Flexible Spending Plan may only reimburse specific covered expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Covered expenses generally do not include such items as premiums paid for health insurance coverage or expenses for non-reconstructive cosmetic surgery.

The Limited Medical FSA Plan may only reimburse expenses covering vision, dental and preventative care and may only be elected by participants who have chosen to participate in the HDHP/HSA.

Dependent Care Flexible Benefits

The Dependent Care Flexible Spending Plan may only cover expenses that enable you to work. If dependent care is required to enable you to work, these expenses may be eligible for reimbursement from the Dependent Care Flexible Spending Account. Included are payments to child care centers and nursery schools up to but not including kindergarten. Eligible expenses may also include 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 non-relative, as long as such a person is reporting payments as income, may also be eligible. The following list details some of the requirements for taking advantage of this Benefit. Please refer to the Plan for more detailed information.

1. The maximum contribution allowed by law per plan year is $5,000. If you are married and filing separately, then the maximum is $2,500.

2. If either you or your spouse has an annual income of less than $5,000, the most that may be deposited into this account is the lesser of the two incomes.

3. Expenses submitted for reimbursement must be necessary to allow you to work. If you are married, your spouse: (1) must work; or (2) be physically or mentally incapable of self-care and have the same principal place of abode as you for more than half of the year; or (3) be a full-time student.

4. To qualify, children must be under age 13. Adults must be physically or mentally unable to care for themselves. All qualified dependents must be claimed on your federal tax return.

5. Payments for providing day care cannot go to someone claimed as a dependent on your federal tax return, nor to your child if under the age of 19. But, payments can go to a non-dependent relative, even if that person lives in your home. The individual receiving payments must report them as taxable income.

6. In order to be reimbursed the full amount of your claim, you must have accumulated a sufficient credit balance in your Dependent Care Assistance Account. If you submit a claim for a greater amount than is in your Dependent Care Assistance Account, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as additional money is contributed from you pay.

HOW TO ENROLL

The Plan generally requires enrollment in the Plan before the Plan Year begins, or in the case of a new employee, before he/she receives any benefit from the Plan. Timing and details of enrollment for new employees are available in the Business Office and in the Plan document.

During the enrollment period, a Benefit Schedule/Election Form with a Salary Reduction Agreement is provided to each employee of the District who is eligible to participate in the Plan. These forms may be provided in electronic versions. The Benefit Schedule/Election Form is the method by which you select which Benefit options you wish to participate in and specify the dollar amount you wish to be allocated for each Benefit. Once the Benefit Option selections are made, you must sign (or electronically submit) the Benefit Schedule/Election Form and the Salary Reduction Agreement, which authorizes the District, as your employer, to reduce your total compensation as indicated.

The total of the amounts allocated to each Benefit of the Plan is automatically deducted from your compensation each pay period either on a before tax basis or after-tax basis dependent upon the type of benefit selected. With the exception of the HSA, once the enrollment period has closed, the benefit elections you made (or declined to make) remain in effect until the end of the Plan Year. In other words, except for elections to contribute to the HSA, the benefit elections are considered irrevocable, except in the case of "a change in status" or HIPAA or CHIPRA special enrollment qualifying event, as determined by the *Internal Revenue Code*, as amended and regulations thereunder.

Salary reduction contributions to an HSA must be prospective. HSA eligible employees may make prospective salary reduction elections or change or revoke salary reduction elections for

HSA contributions at any time (at least once monthly) during the Plan Year, effective before salary becomes currently available.

FAILURE TO MAKE ELECTION

If an employee who participated in the Plan during the preceding Plan Year fails to complete the Benefit Schedule/Election Form by the end of the applicable election period, the employee shall be deemed to have made the same insured Benefit Option elections as are in effect at the end of the preceding Plan Year. Such employee shall be deemed to have elected the amounts necessary to purchase such insured Benefit Options for salary reduction. However, with respect to the Medical Flexible Spending Plans (Limited FSA included) and the Dependent Care Flexible Spending Plan, such failure to elect shall be deemed an election not to participate in those benefits for the subsequent Plan Year and to receive regular compensation to the extent applicable.

If an employee elects not to participate in the Plan, or an employee who had not participated in the Plan during the preceding year fails to complete the Benefit Election Form by the end of the applicable election period, such employee shall be deemed to have elected to receive his regular compensation to the extent applicable.

Notwithstanding the foregoing, an employee who is eligible to participate in the Plan and who is covered by the District's insured Benefits under the Plan shall automatically become a Participant to the extent of the employee's share of the cost of the Premiums for such insurance unless the employee elects during the Election Period, not to participate in the Plan.

HSA election rules are governed by the Plan document and the documents giving rise to the HSA.

WHAT IS A "CHANGE IN STATUS"?

The IRS has established a condition of irrevocability to help avoid abuse of Section 125 flexible benefit plans. With the exception of contributions to an HSA, once a selection is made and money is designated to it, the election can be revoked and a new election made as to the remaining portion of coverage during the Plan Year only if the change or new election is consistent with changes in status as described in IRS regulations, to the extent necessary or appropriate for such change or you experience an event leading to special enrollment rights under either HIPAA or CHIPRA. Examples of changes in status for which a benefit election change may be permitted include the following:

- Marriage or divorce
- Legal separation or annulment
- The birth, adoption, or placement for adoption of a child
- Death of a spouse or dependent
- Termination of a dependent’s status due to attaining age or other event that causes dependent to satisfy or cease to satisfy requirements for coverage
- Termination or commencement of employment of employee, spouse, former spouse, or dependent
- Conversion from part-time to full-time status or full-time to part-time status of employee, dependent, or spouse that affect benefit eligibility
- Commencement of or return from an unpaid leave by employee, dependent, or spouse, including a strike or lockout
- Significant change in health coverage attributable to the spouse’s employment

- Change that results in entitlement to COBRA continuation coverage or loss of COBRA coverage
- Entitlement to or loss of Medicare or Medicaid by employee, spouse or dependent
- Change in the place of residence or worksite of the employee, spouse, or dependent
- Plan administrator's receipt of a QMED child support order (If the QMED requires coverage, the employee may elect to add a child to the Flexible Benefits Plan, if the QMED requires the ex-spouse to provide coverage, the employee may drop the child from the Flexible Benefits Plan.) In such an event, the change in election will be automatically implemented.
- Change in the number of the Participant's family members or dependents who may benefit from Flexible Benefits Plan coverage
- Change in the employment status of employee, spouse, or dependent with the consequence that the individual becomes (or ceases to become) eligible under the Flexible Benefits Plan
- A HIPAA event that would entitle the employee, spouse or dependent to special enrollment rights. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the District's Business Office.

Revocations may also be made due to significant cost or coverage changes at Plan Administrator's discretion when authorized by the Code or its implementing regulations. If the premium cost under a Benefit option provided under the Plan increases or decreases during a Plan Year, then the Plan may automatically increase or decrease, as the case may be, the salary reductions of all affected Participants for such Benefit Option. If the premium cost increases *significantly,* the Plan Administrator may permit the affected Participants to either accept the corresponding changes in their premium payments or revoke their elections and, in lieu thereof, participate on a prospective basis, in another Benefit option with similar coverage, or drop coverage if a Benefit Option with similar coverage is not currently available in the District. If the premium cost decreases *significantly,* the Plan Administrator may permit commencement of participation in the Plan for the option with a decrease in cost. Whether an increase or decrease in cost is significant shall be determined by the Plan Administrator on a reasonable and consistent basis in accordance with prevailing IRS guidance, and based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change.)

In addition, with respect to an election change in health insurance coverage pursuant to the special enrollment provisions of the CHIPRA, if you are eligible but not enrolled for coverage under the terms of the health insurance plan (or your dependent is eligible but not enrolled for coverage under such terms), CHIPRA allows you (or your dependent) to enroll for coverage under the terms of the health insurance plan if either of the following conditions is met:

1. Termination of Medicaid or CHIP Coverage

You or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and your or your dependent's coverage under such a plan is terminated as a result of loss of eligibility for such coverage. (In order to take advantage of this new enrollment option, you must request coverage under the group health plan (or health insurance coverage) not later than sixty (60) days after the date of termination of such Medicaid or CHIP coverage.)

--OR--

2. Eligibility for Employment Assistance Under Medicaid or CHIP

You or your dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). (In order to take advantage of this new enrollment option, you must request coverage under the group health plan (or health insurance coverage) not later than sixty (60) days after the date you or your dependent is determined to be eligible for such assistance.)

FAMILY AND MEDICAL LEAVE ACT

Employees who take unpaid leave pursuant to the Family and Medical Leave Act have the option to continue health benefits while on unpaid leave under the FMLA. A participant who takes an unpaid leave of absence under the FMLA and elects to continue participation under the plan shall be responsible for making the required contributions under the group health insurance plan, in the manner specified in the Plan. If an employee chooses to revoke an election for coverage while on FMLA leave, and subsequently returns to work before the end of the FMLA leave, the employee and eligible dependents will be covered under the Plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave.

Health related expenses are potentially reimbursable under the Medical Flexible Spending Plan if they are considered "medical care" under Section 213 of the *Internal Revenue Code*. Some of these medical care expenses may include:

Acupuncture
Alcoholism treatment
Ambulance hire
Artificial limbs
Artificial teeth
Aspirin **
Bandages
Birth control pills
Braces
Braille books and magazines
Car controls for the disabled
Care for the mentally disabled
Childbirth preparation classes
Chiropractors
Co-insurance amounts you pay
Contact lenses and supplies
Crutches
Dental fees
Dermatologist

Diagnostic fees
Drug addiction therapy
Eyeglasses, including exam fee
Fees for practical nurse
First Aid Kits
Guide dog and its upkeep
Health insurance deductibles
Hearing devices and batteries
Hypnosis for treatment of an illness
Insulin and diabetic supplies
Itemized hospital bills
Laboratory fees
Lamaze classes ONLY
Lasik vision surgery
Lodging for medical care
Mileage for medical care
Nurse's fees
Obstetrical expenses
Operations
Orthodontic treatment
Orthopedic shoes
Over the Counter Medicines**
Oxygen
Physician's fees
Prescription drugs
Psychiatric care
Routine physical
Smoking cessation program/related drugs
Sterilization fees
Surgical fees*
Telephone for the hearing impaired
Television display for hearing impaired
Therapy treatments
Tuition at special schools for disabled
Wheelchair
Wigs - for medical reasons
X-rays

*Cosmetic surgery is defined in 26 U.S.C. 213 in the Code. Basically, unless the cosmetic surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease, it will not be eligible for reimbursement under the Medical Flexible Spending Plan.

**As of January 1, 2011, a prescription for over the counter medications is required to be reimbursable under the Medical Flexible Spending Account.

Note: to the extent that an above expense has been reimbursed by insurance or another source, the expense is not eligible for reimbursement from the Medical Flexible Spending Account.

HOW ARE CLAIMS FOR REIMBURSEMENT FROM THE FLEXIBLE SPENDING ACCOUNTS SUBMITTED?

To receive reimbursement from one of the Flexible Spending Accounts, you must complete a claim form from the Business Office and submit it along with your paid bills and other required documentation to substantiate the claim to the Business Office for processing through the District's third party administrator, Genesis. The District has designated Genesis to be the claims administrator. After the claim is submitted to __Genesis, you will be reimbursed the full amount of your eligible expenses up to your elected Medical Flexible Spending Account (or Limited FSA, where appropriate) pretax deferral amount provided the expense is appropriately substantiated. However, you must have accumulated a sufficient credit balance in your Dependent Care Flexible Spending Account in order to receive full reimbursement from that account. Please note that reimbursements will occur at least once per month. Note that Genesis may establish claims procedures outside of this SPD that include electronic submission.

Types of acceptable documentation to substantiate the claim include but are not limited to:

- An explanation of benefits from the insurance company showing the deductible applied, coinsurance and the portion of expenses not paid by insurance.
- A receipt showing the expense incurred.
- A canceled check (e.g., a check issued to pay a babysitter).

HOW ARE CLAIMS FOR REIMBURSEMENT FROM THE HSA SUBMITTED?

Any claims submitted for reimbursement from the HSA shall be performed in accordance with the HSA documents provided by the HSA trust. Please refer to these forms for further information.

FORFEITURES

THE *INTERNAL REVENUE CODE* REQUIRES FORFEITURE OF ANY FUNDS REMAINING IN THE FLEXIBLE SPENDING ACCOUNTS AT THE END OF THE PLAN YEAR for which documented reimbursement has not been requested prior to the end of the Plan Year runout period. Please note that you have 60 days following the end of the Plan Year to submit all of your eligible expenses for reimbursement. This is known as a runout period.

TERMINATION OF EMPLOYMENT

If you terminate your employment with the District for any reason other than death, your participation in the Plan shall be governed in accordance with the following:

1. With regard to Benefit Options that are insured, where your employment terminated during the Plan Year prior to your completion of your employment contract for the immediate school year, your participation in the Plan shall cease, subject to the right to continue coverage under any Insurance Contract for which premiums have already been paid or rights under COBRA - (IRC 4980B) or applicable state law.

2. With regard to Benefit Options that are insured, if you are a non-Administrator and your employment terminated during the Plan Year but after your completion of your employment contract for the immediate school year, your participation in the Plan shall continue through the end of the Plan Year (August 31), subject to the right to continue coverage under any Insurance Contract for which premiums will be or have already been

paid. Participation thereafter shall be pursuant to rights under COBRA - (IRC 4980B) or applicable state law. Note that Administrator's coverage will terminate on June 30 rather than August 31. For example, your employment with the District is based upon the school year and your employment terminates on the last day of school, June 6, 2013; because you have fulfilled your contract for the 2012-2013 school year, your coverage under the Plan shall continue until August 31, 2012. Salary reduction for such coverage will continue as long as you receive a paycheck from the District throughout such period. Note that independent employment contracts that establish a contract year other than July 1 – June 30, may have a different termination date for such coverage.

3. With regard to the Dependent Care Assistance Program, your participation in the Plan shall cease and no further Salary Reduction contributions shall be made unless you have fulfilled the terms of your employment contract for the school year in which your employment terminated and you continue to make contributions to the Plan, in which case, your participation shall continue until the end of the Plan Year (June 30 for Administrators, subject to specific terms in employment contracts). You may submit claims for employment related Dependent Care Expenses incurred prior to the date of termination up to the amount available in your Dependent Care Assistance Account as of the date of termination for 60 days following your termination.

3. With regard to the Medical Flexible Spending Plans (Limited FSA included), your participation in the Plan shall cease and no further Salary Reduction contributions shall be made unless you have fulfilled the terms of your employment contract for the school year in which your employment terminated and you continue to make contributions to the Plan, in which case, your participation shall continue until the end of the Plan Year (June 30 for Administrators), subject to specific terms in employment contracts. You may submit claims for expenses incurred during the portion of the Plan Year preceding your date of termination for 30 days following your termination, up to the maximum benefit elected less all prior reimbursement amounts. You may also be eligible to elect COBRA.

.

OTHER IMPORTANT PROVISIONS

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 must satisfy 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, regarding the Plan's procedures for determining whether the medical child support order is qualified.

COBRA COVERAGE

The *Consolidated Omnibus Budget Reconciliation Act of 1986* ("COBRA") permits you and your qualified beneficiaries to elect to continue group health insurance coverage if, among other reasons, you voluntarily or involuntarily terminate your employment, for reasons other than "gross misconduct", or, if as a result of your hours being reduced, you are no longer eligible for group health insurance coverage from your employer. Please note that your COBRA rights with respect to continuation of group health insurance coverage are separate and distinct from your COBRA rights with respect to continuation of your participation in the Medical Flexible Spending Plan benefit. Your COBRA rights with respect to continuation of your participation in the Medical Flexible Spending Plan benefit are summarized below. Information regarding your COBRA rights with respect to the continuation of group health insurance coverage can be obtained from the District's Business Office.

You may elect to continue your participation in the Medical Flexible Spending Plan benefit *for the remainder of the Plan Year* during which you experience a "qualifying event" (*i.e.,* including, but not limited to, voluntary or involuntary termination from employment, for reasons other than "gross misconduct" or reduction in the number of hours of employment resulting in a loss of eligibility). The District has adopted rules for claims procedures and elections under COBRA. **[Those rules are attached to this Summary Plan Description and incorporated into the Plan.]** You and your dependents may be eligible for additional continuation coverage under applicable Illinois law. Please check with the Plan Administrator if you have additional questions.

FUTURE OF THE FLEXIBLE BENEFITS PLAN

The ~~Cafeteria/~~ Section 125 Flexible Benefits Plan is based on the District's understanding of the current provisions of the *Internal Revenue Code*. The District reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable, or if the District otherwise deems it appropriate to do so. Although the District may alter or cancel benefits prospectively, if the Plan is amended or terminated, it will not affect any benefit to which you were entitled for claims incurred before the date of the amendment or termination.

LIMITATION

No provision of this Plan is to be considered a contract of employment between any employee and the Wilmette School District No. 39. Participation in this Plan is available for all Wilmette School District No. 39 employees who meet the eligibility requirements.

Plan Administrator: Board of Education Wilmette School District No.39

Employer Identification Number (EIN): 36 - 6004267

Third Party Claims Administrator:
Genesis