Los Alamitos Unified School District

Flexible Spending Account Plan
Summary Plan Description

Restated: January 1, 2015

Plan Highlights

• The purpose of the Flexible Spending Account (FSA) Plan is to provide a tax-savings plan for paying out-of-pocket health, dental, vision and dependent care expenses.

• Contributions to the Plan may be made to these FSA Accounts:

- Health Care Account for unreimbursed health, dental and vision care expenses
- Dependent Care Account for dependent care expenses
- Adoption Assistance Program

• FSA contributions are made on a "pre-tax" basis. This means that some deductions are not subject to federal or state income taxes or Social Security and Medicare taxes under the Federal Insurance Contribution Act (FICA). As such, pre-tax payroll deductions may result in higher net income. Pre-tax deductions may also decrease Social Security Earnings.

• The maximum annual contributions are listed below:

- Health Care Account FSA $2,500
- Dependent Care Account $5,000 per year.
- Adoption Assistance Program $13,400 per child.

• Reimbursement may be made as frequently as on a weekly basis. Claims are processed by Benefit & Risk Management Services (BRMS), a third party FSA claims administrator.

• Dependent Care FSA: All remaining balances as of March 31st of each year are forfeited. All claims with dates of service/receipts of January 1 through December 31st must be submitted to BRMS by March 31st of the following year.

• Health Care FSA: All remaining balances as of March 31st of each year are forfeited. All claims with dates of service/receipts of January 1 through December 31st must be submitted to BRMS by March 31st of the following year.

• Individuals must re-enroll in the FSA Plans during the fall Open Enrollment in order to continue participation during the next calendar year.

IDENTIFYING INFORMATION

1. Plan Name and Number:

   The Los Alamitos Unified School District Flexible Benefits Plan; Plan Number 501.

2. Employer Name and Address:
Los Alamitos Unified School District
10293 Bloomfield Street
Los Alamitos, CA 90720

3. Employer Identification Number: 95-3506685

4. Plan Administrator and Agent for Service for Process:

Los Alamitos Unified School District
10293 Bloomfield Street
Los Alamitos, CA 90720
(562) 799-4700

5. Claims Administrator:

Your Employer has retained Benefit & Risk Management Services (BRMS) to assist in Plan Administration. ***All claim forms should be submitted to:***

BRMS
P.O. Box 1697
Folsom, CA 95763

Or Fax to: 866-410-0880

6. Plan Year-End: December 31

Purpose

The purpose of the Flexible Spending Account (FSA) Plan is to provide a tax savings plan for paying out-of-pocket health, dental, vision and dependent care expenses.

Plan Administrator

Los Alamitos Unified School District (Employer) is the Plan Administrator and has the responsibility for operating and interpreting the Plan. Day to day administrationof the Plan is performed by the District Office.

Claims Administrator

BRMS is the Claims Administrator for the FSA Plans including the regular Health Care, Dependent Care, Adoption Assistance Program.

For Further Information

The information contained in this Summary Plan Description is intended to summarize the major features of the FSA Plan. It is not intended to be a complete explanation or list of benefits provided by the FSA Plan.

An individual should review Internal Revenue Service Publications #502, *Medical and Dental Expenses* and #503, *Child and Dependent Care Expenses* for additional information.

Continuation of the Plan

The Employer intends to continue this Plan indefinitely, but reserves the right to modify or terminate the Plan at any time with or without notice.

Participation in this Plan is provided to eligible faculty and staff and does not constitute a guarantee of employment. Participation in the Plan also requires continued employment and eligibility and is subject to the terms and conditions of the Plan Document.

Definitions

In this section, you will find the definitions for the italicized words found throughout this summary plan description. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions should not be interpreted as indications that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.**

"**Actively at work**" **or** "**active employment**" means performance by the employee of all the regular duties of his occupation at an established business location of the participating employer, or at another location to which he may be required to travel to perform the duties of his employment. An employee will be deemed actively at work if the employee is absent from work due to a health factor.

"**Alternate recipient**" means any child of a participant who is recognized under a medical child support order as having a right to benefits under this Plan as a participant's dependent. For purposes of the benefits provided under this Plan, an alternate recipient shall be treated as a dependent, but for purposes of reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a participant.

"**Annual enrollment period**" means the designated enrollment period when eligible employees may enroll for participation and make elections under the Plan for the following plan year.

"**Benefit plan**" means the medical, prescription drug, over-the-counter drug, hearing, dental, and vision benefits provided under a group health plan established and maintained by the Plan Sponsor, or any successor thereto.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Cosmetic surgery**" means any procedure that is directed at improving the person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

"**Debit card**" means a banking card enhanced with ATM (automated teller machine) and POS (point-of-sale) features, issued by the Plan Sponsor to a participant that can be used to pay for qualified medical flexible spending expenses electronically.

"**Dependent**" means any of the following individuals who meet the definition of "dependent" under Internal Revenue Code Section 152:

- Children and grandchildren of the participant;
- Stepchildren of the participant; and
- Siblings of the participant.

The child need ***not***: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.

Additionally, children of a participant who is divorced, legally separated, separated under a written separation agreement, or who has lived apart from his or her spouse at all times during the last 6 months

of the calendar year, will be a dependent so long as they receive over one half of their support from their parents and are in the custody of one or both parents for more than one half of the calendar year.

Based on recent changes made by the health care reform legislation, tax-free reimbursement of medical expenses may be permitted, based on your employer's plan, for adult children up to age 26. Please note that any questions regarding the status of an individual as either a qualifying child, qualifying relative, or an adult child must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's plan.

"**Employee**" means an individual who meets Los Alamitos Unified School District eligibility requirements.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"**FMLA**" means the Family Medical Leave Act of 1993, as amended.

"**FMLA leave**" means a leave of absence which the participating employer is required to extend an employee under the provisions of FMLA.

"**Health care expense**" means an expense incurred for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. A health care expense is not one that is merely beneficial to the general health of an individual.

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

"Incurred" means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, qualified medical flexible spending expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

"**Medical child support order**" **or** "**MCSO**" means any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a participant's child or directs a participant to provide coverage under a health benefit plan pursuant to a state domestic relations law (including community property law); or

- Enforces a law relating to medical child support described in Section 13822 of the Omnibus Budget Reconciliation Act of 1993 with respect to a group health plan.

"**Participant**" means an eligible employee who is participating in the Plan.

"**Participating employer(s)**" means Los Alamitos Unified School District.

"**Plan**" means the Los Alamitos Unified School District Flexible Spending Account.

"**Plan Administrator**" means Los Alamitos Unified School District.

"**Plan document**" means this plan document for the Los Alamitos Unified School District Flexible Spending Account.

"**Plan Sponsor**" means Los Alamitos Unified School District.

"**Plan year**" means the period from January 1 through December 31 each year.

"**Privacy standards**" means the final rule implementing HIPAA's Standards for Privacy of Individually Identifiable Health Information, as amended.

"**Qualified beneficiary**" means**:**

- An individual who, on the day before a qualifying event, is a spouse or dependent child receiving benefits under the plan; or

- In the case of a qualifying event resulting in termination of coverage due to termination of employment or reduction in hours, an individual who, on the day before such qualifying event, is a participant.

A newborn child of, an adopted child of, or a child placed for adoption with, a qualified beneficiary (as defined in the first bullet above) will be entitled to the same continuation coverage period available to the qualified beneficiary; however, such child shall not become a qualified beneficiary.

A newborn child or child placed for adoption with a qualified beneficiary (as defined in the second bullet above) shall become a qualified beneficiary in his or her own right and shall be entitled to benefits as a qualified beneficiary.

A qualified beneficiary must notify the Plan Administrator within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the continuation coverage.

"**Qualified medical flexible spending account**" means the account established by the Plan Administrator on behalf of the participant through which the participant may elect to reduce his salary in order to pay qualified medical flexible spending expenses.

"**Qualified medical flexible spending expenses**" means a health care expense which is excludable as income according to Code § 105(b). Qualified medical flexible spending expenses are not otherwise reimbursable under the benefit plan or other plan or by any other entity and may not be claimed as a tax deduction by the participant. Qualified medical flexible spending expenses do not include the cost of insurance premiums.

"Qualified reservist distribution" means, any distribution to an individual of all or a portion of the balance in the participant's qualified medical flexible spending account if:

- Such individual was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code) ordered or called to active duty for a period in excess of 179 days of for an indefinite period; and

- Such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such arrangements for the plan year which includes the date of such order or call.

"**Qualifying event**" means any of the following with respect to participation in the Plan:

- The termination of coverage due to the death of a participant;

- The termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a participant;

- The divorce or legal separation of a participant from his or her spouse;
- A participant's entitlement to Medicare coverage during an 18-month continuation period; or
- A dependent child ceasing to be a dependent child.

"**Salary reduction agreement**" means a paper enrollment which is classified as a salary agreement.

"Security standards" mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"**Spouse**" means an individual who is legally married to a participant, but shall not include an individual legally separated from a participant under a decree of legal separation.

"Student" means an individual who, during each of five calendar months during a taxable year, is a full-time student at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

"**Summary health information**" means individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

"**Summary plan description**" means this Plan Document and Summary Plan Description. This summary plan description represents both the Plan Document and the Summary Plan Description that is required by ERISA.

"**Third party administrator**" means Benefit & Risk Management Services (BRMS).

"**Uniformed services**" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

"**USERRA**" means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

Eligibility

This section summarizes eligibility requirements for participation in a Flexible Spending Account Plan.

Salary Requirement

An individual must receive Employer compensation paid by the Employer's payroll system and his or her salary must be sufficient to cover the amount of monthly contribution.

Employee Classification

To be eligible for the Plan, the individual must be regularly scheduled to work at least 20 hours a week for the Employer. If you are an eligible employee, you qualify to elect benefits under the Plan by becoming a Plan Participant as soon as you start working for the Employer.

Disabled Individuals An individual who becomes permanently and totally disabled while working for Los Alamitos Unified School District and is receiving Group-sponsored Long Term Disability benefits remains eligible to participate in the FSA Plan.

Individuals on a Leave of Absence An individual on a paid leave of absence may continue making contributions by payroll deduction to and receive reimbursement from his or her FSA account. An individual on a leave of absence without pay may continue to make contributions to the plan on an after tax basis and submit FSA claims for reimbursement. Contributions may not be made to the FSA Dependent Care Account though individuals may continue to seek reimbursement for services prior to the leave period.

Retired Individuals An individual who retires from the Employer may continue to submit claims for reimbursement during the period he or she was contributing to an FSA account but may not continue to make contributions to the FSA Dependent Care Account after retiring.

Deceased Individuals A spouse or dependent child of a deceased individual is not eligible to participate in the FSA Plan other than to submit claims for reimbursement for services received prior to the individual's death.

Other Eligible Individuals

Spouse

A spouse must be legally married to and have his or her principal residence with the eligible individual.

Surviving spouse and children of a deceased individual

An eligible spouse or dependent child of a deceased individual or retired individual may continue to submit claims for reimbursement for services received up to and including the date of death but may not make contributions to the Dependent Care Account.

Domestic Partner

An individual's same-gender domestic partner and dependent children of the domestic partner are **not** eligible for FSA participation.

Dependent child

Dependent children include children, stepchildren and disabled siblings of the participant. The child need ***not***: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed. This will not apply to dependents under age 26 who are eligible or covered by another group health plan.

Any children who are dependent upon an individual for financial support and maintenance because of mental retardation or physical disability will be eligible regardless of age.

Dependent children do not include grandchildren. The Employer reserves the right to require sufficient proof of dependent status in determining eligibility. No individual may be covered more than once under the Employer's benefit plans.

Parents and grandparents
An individual's parents, grandparents and in-laws are not eligible to participate in the FSA plan unless they are a disabled adult who is not your spouse, did not have gross income for the calendar year that was more than the amount of the personal exemption deduction under Federal Law for that year.

Duration of Eligibility
Participation in the Plan may continue for as long as an individual remains an eligible individual and receives a salary.

Contribution Limits

This section highlights plan choices offered by the FSA Plan. Eligible faculty and staff may choose to participate or waive participation in the FSA.

- **Dependent Care Account**
- **Health Care Account**
- **Adoption Assistance Program**

Eligible individuals may also elect the amount of contributions up to:

- $5,000 Dependent Care Account annual maximum contribution
- $2,500 Health Care Account annual maximum contribution
- $13,400 Adoption Assistance Program total maximum contribution for 2012

Deduction Schedule

All individuals are paid on a monthly basis. Deductions for FSA accounts will be made on a tenthly basis.

Dependent Care Flexible Spending Account

Summary
The purpose of the FSA Dependent Care Account is to provide a tax-savings program to assist eligible individuals fund work related dependent care expenses such as for a day care center or for in-home child care providers.

Eligibility
To qualify for reimbursement from the Dependent Care Account, dependent care expenses must be necessary for an individual (and his or her spouse, if married) to work. The expenses must be for the well-being and protection of a qualified dependent.

General Requirements
In addition to eligibility requirements, an individual may participate in the Dependent Care Account if he or she has an eligible dependent and meets one of the following requirements:

- The individual is a single parent, or
- The individual has a working spouse, or
- The spouse is a full-time student for at least five months during the year while an individual is working, or
- The spouse is disabled and unable to provide for his or her own care, or
- The individual is divorced or legally separated parent who has child custody most of the time, even if the other parent may claim the dependent for tax purposes.

Dependents
Eligible dependents include:

- Any child under age 13 who is claimed as a dependent for federal income tax purposes.
- Any other dependent who normally spends at least eight hours in the home each day and who is unable to care for himself or herself because of a physical or mental disability. The person may be a child age 13 or over, a spouse, a parent, etc.

Examples of Eligible Expenses
An individual may be reimbursed for dependent care which is provided:

- Inside or outside the home by anyone other than a spouse, a dependent claimed on his or her income tax return, or a child under age 19.
- In a day care or child care center. (If the center cares for more than six children, it must comply with state and local regulations.)
- By a housekeeper whose services include, in part, providing care for an eligible dependent.

Examples of Ineligible Expenses

The following are examples of dependent care expenses which do not qualify for reimbursement:

- Expenses for food, clothing, education or entertainment, unless they are incidental and cannot be easily separated from the cost of dependent care.

- Schooling in the first grade or beyond.

- Nursing home expenses.

- Payments made to a spouse or to any person declared as a dependent for income tax purposes.

IRS Tax Rules

The IRS permits a participant to take a federal tax credit on his or her annual income tax return for dependent care expenses. However, the amount deposited to the Dependent Care Account will reduce, dollar-for-dollar, the amount used toward the federal tax credit.

For some individuals, the tax savings is greater if they pay for dependent care expenses through the reimbursement account. For others, it is greater if they take a tax credit on their annual income tax returns.

For more information about the federal tax credit, an individual can call the IRS at (800) 829-3676 and ask for publication #503 *Child and Dependent Care Expenses* and for publication #596 *Earned Income Credit*. Publication #503 provides a list of eligible and ineligible expenses for both the tax credit and reimbursement account.

Individuals are encouraged to consult a credible tax advisor if there are any questions about whether the reimbursement account or tax credit is more advantageous.

Maximum Contribution Limits

Under IRS regulations, the maximum amounts an individual may contribute to the FSA Dependent Care Plan are:

For individuals filing taxes as single or married filing jointly the maximum annual contribution amount is $5,000

For individuals married and filing taxes separately the maximum annual contribution amount is $2,500 each

Minimum contribution: The minimum contribution is $150 per year.

Health Care Flexible Spending Account

Summary

The purpose of the FSA Health Care Account is to provide a tax-savings program for an individual to reimburse himself or herself for out-of-pocket expenses not covered by an individual's medical, dental or vision plans or a spouse's plans.

Maximum contributions: The maximum annual contribution is $2,500.
Minimum contributions: The minimum contribution is $150 annually.

Eligible Expenses

Expenses that qualify for reimbursement under the Health Care Account must meet the following requirements:

The expense must not be covered by a health, dental or vision plan or spouse's plan. The expense must be included in the IRS list of eligible tax deductible expenses.

The expenses must be incurred by the participant or his or her eligible dependents (spouse and any children). To qualify, the dependent must be claimed as a tax exemption on the individual's federal income tax return.

Eligible expenses can be taken either as a tax deduction on the annual federal income tax return (IRS form 1040) or used toward Health Care Account reimbursement. An individual must select one method or the other because a deduction cannot be claimed for an expense that has been reimbursed through the FSA account.

Examples of Eligible Expenses

Typically, eligible out-of-pocket health care expenses are expenses incurred for medical care. Such expenses include amounts paid for the diagnosis and treatment of illness or injury including prescription drugs.

Eligible medications must have a prescription to be claimable.

Expenses must be for the treatment of an existing disease or to prevent a disease that is likely to occur if the medication is not taken. They do not include toiletries and cosmetics, vitamins and dietary supplements or herbal remedies.

Examples of Ineligible Expenses

The following are examples of health care expenses which do not qualify for reimbursement:
Health insurance premiums, Medicare Part B premiums, Vitamins, Marriage or family counseling, Custodial care in an institution, Health club dues and Homeopathic medicine and Over the counter medications without a prescription.

For more information about the qualified medical and dental expenses, an individual can call the IRS at (800) 829-3676 and ask for publication #502 *Medical and Dental Expenses*

Adoption Assistance Program

The Adoption Assistance Program option provides reimbursement to you for the reasonable and necessary expenses that you incur in the process of legally adopting an eligible child, including adoption fees, court costs and attorney fees. Expenses that are not eligible for reimbursement include expenses incurred in violation of state or federal law, expenses incurred in carrying out a surrogate parenting arrangement, and expenses in connection with the adoption of a step-child. An "eligible child" is a child who has not yet reached age 18 or is physically or mentally incapable of caring for himself or herself. The maximum amount of reimbursement that you may receive in connection with the adoption of any one child is $13,400. **This is a total rather than an annual amount, even if the expenses occur over a period of years.**

What are the tax benefits of reimbursement under the adoption expense reimbursement Plan?

If your adjusted gross income (together with that of your Spouse if you are married and filing a joint tax Return) is $189,710 (this $189,710 will be adjusted for inflation in years after 2012) or less, you can exclude from your gross income in computing your income tax liability the entire amount of adoption expense reimbursement you receive under this Plan (subject to the $13,400 cap). However, if your adjusted gross income exceeds $189,710, the portion of adoption expense reimbursement that may be excluded is reduced from $13,400 based on the following formula:

$13,400 x [(adjusted gross income -$189,710) / $40,000]

If, for example, your adjusted gross income were $209,710, and you incurred $13,400 or more in expenses to adopt a child, your maximum exclusion would be $6,325, calculated as follows:

$13,400 x ($20,000 / $40,000), or $12,650 x .5 = $6,325

$13,400 total expenses-$6,325 pre-tax reduction = $6,325 of expenses that may be reimbursed pre-tax

Generally, any amounts paid to reimburse you for eligible adoption expenses would be excluded from your income for the year of the reimbursement. However, should you adopt a child who is not a citizen or resident of the United States, all amounts reimbursed to you would be excludable from your income only in the year in which the adoption becomes final.

While the amount of your salary that is withheld to pay adoption expenses is excluded from your income in determining your income tax liability, FICA (Social Security) and FUTA (Unemployment) taxes still apply.

What affect will participation in the Adoption Assistance Program have on my right to the adoption expenses credit on my tax return?

The federal tax laws also provides a tax credit (reducing federal tax liability) for adoption expenses that are not reimbursed by an employer or paid under a state or federal grant program. The maximum amount of the credit is $13,400 per adoption. You may claim the credit and receive nontaxable reimbursements from an Adoption Assistance Account in connection with the same adoption, but you may not take a credit and receive reimbursement for the same expense. Because any election for benefits under the Adoption Assistance Program should be coordinated with the use of the credit, the Administrator strongly recommends that you seek advice from your own tax adviser before electing benefits under the Adoption Assistance Program.

Contributions

This section summarizes premium contributions for the FSA Plan.

Contribution Tax Status

Contributions are deducted from paychecks on a pre-tax basis. This means that the contribution amount is excluded as taxable earnings. However, the Adoption Assistance Program is subject to FICA and FUTA.

Contribution Deduction Schedule

All individuals are paid on a monthly basis and contributions are deducted from the paycheck on a tenthly basis.

Individuals on Leave

Individuals on a paid leave of absence may continue to pay contributions by payroll deduction.

Individuals on an Unpaid Leave of Absence

Individuals may continue FSA Health Account participation and contributions by paying monthly contributions by check payable to BRMS and submitted to BRMS – Flex Department.

The contribution amount must be the same amount as the individual was making prior to leave. An individual may continue to submit claims for services received prior to the leave but may not continue Dependent Care Account contributions while on an unpaid leave.

Enrollment Procedures

This section summarizes enrollment procedures and deadlines.

Initial Hire or Benefits Eligibility

An individual must enroll in a FSA Plan by completing the enrollment process no later than 31 days from the date of hire or initial benefits eligibility.

After Hire or Initial Benefits Eligibility

After hire or initial eligibility, an individual may elect FSA participation; change the amount of the contribution as a result of marriage, birth or adoption of a child provided the individual notifies the Benefits Division and completes the enrollment process no later than 31 days from the date of a change in family status. During Open Enrollment, an individual may elect to enroll or re-enroll in the FSA Plan.

Re-enrollment Requirement

Faculty and staff must re-enroll in the FSA plan in order to continue participation for the next calendar year.

Effective Dates of Coverage

This section summarizes coverage effective dates for FSA Plan coverage.

Initial Hire or Benefits Eligibility

The effective date of FSA coverage is the first day of employment after completion of enrollment materials.

After Initial Eligibility

The effective date of FSA coverage is based on the date of a qualifying change in employment or family status. An individual may drop FSA coverage by submitting a completed benefit withdrawal form to the District Office no later than 31 days from the date of a qualifying change in family or employment status. The effective date of FSA coverage elected during Open Enrollment is January 1st.

Claims

This section summarizes the procedures and deadlines for submitting a claim for reimbursement from a FSA account.

BRMS is the plan administrator of the Dependent Care FSA plan. You may register online at www.brmsclaims.com to view your contributions, and claim status.

Dependent Care Account Claims

Claimable dates of service are from the date of eligibility to December 31st of that Plan Year. Participants have until the end of March of the following Plan Year to file claims for expenses incurred during the previous Plan Year. All claims must be submitted to BRMS by March 31st of the following year. **Any deposits from the previous Plan Year that remain in the account on April 1st of the following Plan Year must be forfeited under IRS regulations.**

If an individual terminates employment or retires, he or she has until the annual claim filing deadline to submit claims for the reimbursement of expenses incurred prior to termination. Unlike the FSA Health Care Account, an individual may not continue participation in the Dependent Care Account following termination.

Required Information

When submitting a claim, the claim must show the name, Social Security number or federal tax ID number of the care provider and reimbursement amount. The Social Security and federal tax ID numbers are not necessary if the care provider is a tax-exempt group, such as a church or if the care is provided outside of the United States by a foreign citizen. The dependent's name, relationship to the individual, age and dates of service should also be provided. Appropriate receipts, invoices or other documents should be attached. Otherwise, the care provider may record this information on the claim form along with his or her signature.

Amount of Reimbursement

There is no minimum claim amount. Unlike reimbursement protocols for the Health Care Account which enable an individual to receive reimbursement of up to the full annual amount regardless of the amount deposited, the maximum reimbursable amount cannot exceed an individual's current account balance. If the claim exceeds the current account balance, the individual will be paid in installments after each paycheck when contributions are made to their FSA.

Reimbursement after a Change in Family Status

Reimbursement relating to a spouse or dependent child added as a result of a change in family status applies only to services received during the new coverage period for the covered individual.

Appealing a Denied Claim

If the claim is denied in whole or in part, an individual will receive a written Explanation of Benefits giving the reasons for the denial. If an employee wishes to appeal, he or she may contact the plan administrator BRMS at 888-326-2555. Their customer service department will be able to assist you in the process of appeals or understanding what proof may be needed to get the claim paid.

If after contacting the plan administrator you would like to have further assistance, you may contact the District Office at 562-799-4700, extension 80409. The District Office may be able to assist you further. Documentation and a request for appeals in writing may be requested and the plan administrator may be contacted to review these documents and pertinent Plan documents regarding the situation.

A decision will be made on the appeal within 60 calendar days after the request for review is received, unless special circumstances arise. In such cases, an individual will be notified that up to 60 additional days may be required.

Plan Administrator decisions concerning appeals will be final and binding on individuals, dependents and all other interested parties. In no event will a participant or a family member be entitled to challenge a decision of the Plan Administrator in court or in another administrative proceeding, until all appeal procedures described above have been exhausted.

Health Care Account Claims

Health Care FSA members must use their debit card or submit paper claims for reimbursement. You may obtain claim forms from BRMS. You will need to complete the claim form and attach a receipt of service; then fax the claims to BRMS using the fax number from the form.

Deadline for Filing Health Care FSA Claims are from the date of eligibility during the current Plan Year, to December 31st of the current Plan Year. Participants will have until March 31st of the following Plan Year to submit those dates of service. Any money not claimed by April 1st, of the following Plan Year will be forfeited under IRS regulations.

The only exception to the rule for withdrawing Health Care FSA claims is for qualified reservist distributions. Under the Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008, § 114, you are eligible to receive a tax-free distribution of unused benefits in a health flexible spending arrangement if you are a member of an Armed Forces reserve component who is ordered or called to active duty. If you receive an order or call to report to active duty in the U.S. uniformed services for a period of at least 180 days or for an indefinite basis, and you have a remaining balance in your Health Care FSA, to prevent forfeiture of this balance, you will be permitted to request a qualified reservist distribution of that amount provided you make a request for such distribution to the Claims Administrator, in accordance with the Claim Administrator's procedures, after your order or call to active duty and prior to the end of the grace period. Please contact the Claims Administrator for further details.

Required Documentation

To file a claim for reimbursement from the Health Care Account, an individual must submit evidence of a qualified expense.

Examples of proper claim documentation include:

- A document referencing the date of service, provider, amount billed and paid, and the type of service.
- A canceled check accompanied by a third party statement as verification of the incurred health care expense.
- An Explanation of Benefits (EOB) statement received from a medical or dental insurance plan.

Amount of Reimbursement

There is no minimum claim amount. If the amount of a health care account claim exceeds the current reimbursement account balance, the claim will be paid up to the total amount an individual will deposit for the current year. If this results in a temporary negative account balance, deposits for the remainder of the year will be used to repay the negative balance.

All Health Care FSA money is available from date of eligibility.

Reimbursement after a Change in Family Status

Reimbursement relating to a spouse or dependent child added as a result of a change in family status applies only to services received during the new coverage period for the covered individual.

CLAIMS REVIEW PROCEDURE

Upon receipt of complete information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the third party administrator within 45 days from receipt by the participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify you, in accordance with the provisions set forth below, of any adverse benefit determination within the following timeframes:

- If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by you and the Plan Administrator.

Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide you with a notice, in writing, containing the following information:

- A reference to the specific portion(s) of the summary plan description upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that you are entitled 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;

- The identity of any medical or vocational experts consulted in connection with a claim, even if

the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to you, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- You at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

- You the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

- That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances.

Requirements for Appeal

You must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, your appeal must be addressed as follows and mailed or faxed as follows:

Benefit & Risk Management Services (BRMS)
PO Box 1697
Folsom, CA 95763-1240
888-326-2555

It shall be your responsibility to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the participant;
- The participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the participant will lose the right to raise factual arguments and theories which support this claim if the participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the participant has which indicates that the participant is entitled to benefits under the Plan.

If you provide all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

- The Plan Administrator shall notify you of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide you with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the summary plan description on which the denial is based;

- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request;

- A statement of your right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the Plan Administrator shall provide you access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final
If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 30 days after the Plan's claim review procedures have been exhausted.**

Appealing a Denied Claim
If the claim is denied in whole or in part, an individual will receive a written Explanation of Benefits giving the reasons for the denial. If an employee wishes to appeal, he or she may contact the plan administrator BRMS at 888-326-2555. Their customer service department will be able to assist you in the process of appeals or understanding what proof may be needed to get the claim paid.

A decision will be made on the appeal within 60 calendar days after the request for review is received, unless special circumstances arise. In such cases, an individual will be notified that up to 60 additional days may be required.

Plan Administrator decisions concerning appeals will be final and binding on individuals, dependents and all other interested parties. In no event will a participant or a family member be entitled to challenge a decision of the Plan Administrator in court or in another administrative proceeding, until all appeal procedures described above have been exhausted.

Changes in Employment or Family Status

This section summarizes the impact of changes in employment or family status on FSA Account coverage. The effective date of the change will be the date of the Family Status event. Changes in Employment or Family Status can affect dependent care as well. Please see the eligibility section on page 9.

After hire or initial eligibility, an individual may elect coverage, change his or her annual election or drop coverage as a result or a qualifying change in family or employment status by completing the benefits change form within 31 days from the date of a qualifying change in family status.

Leaves of Absence

An individual may continue to submit FSA claims for services received during the period he or she was actively making contributions to the FSA Account. Contributions may not be made to the Dependent Care Account during an unpaid leave period.

If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. If you elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay your contributions in accordance with the options outlined above for a participant who goes on FMLA leave.

While in uniformed service, there is an exception to the withdrawal of qualified medical expenses without a qualified medical expense for qualified reservist distributions (QRD). Under the Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008, § 114, you are eligible to receive a taxable distribution of unused benefits in a health flexible spending arrangement if you are a member of an Armed Forces reserve component who is ordered or called to active duty. If you receive an order or call to report to active duty in the U.S. uniformed services for a period of at least 180 days or for an indefinite basis, and you have a remaining balance in your Health Care FSA, to prevent forfeiture of this balance, you will be permitted to request a qualified reservist distribution of that amount provided you make a request for such distribution to the Claims Administrator, in accordance with the Claim Administrator's procedures, after your order or call to active duty and prior to the end of the grace period. Please contact the Claims Administrator for further details.

Termination of Employment

Participation in an FSA Account generally ends at the end of the month employment is terminated or an individual no longer meets the eligibility requirements (i.e., change to a position not eligible for benefits). An individual has until the annual claim filing deadline of that year to submit claims for the expenses incurred prior to termination of employment or loss of benefits eligibility. An individual may continue participation in the Health Care Account on an after-tax basis by electing COBRA continuation coverage.

Continuation of Rights Under COBRA

An individual may elect to temporarily continue participation in the FSA Health Care Account for expenses incurred after the termination date. Contributions for this period must be made on an after-tax basis and must be the same monthly amount as was being contributed prior to termination. These continuation rights are extended under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Under COBRA, participation in the Health Care FSA may be continued through the end of the calendar year in which termination of employment occurs. Contributions must be made by check, once per month, on an after-tax basis. Therefore, during the continuation period, an individual is not eligible for the pre-tax reductions in taxable income and income taxes that applied during active employment.

The amount of monthly deposits during the COBRA continuation period must be the same as monthly payroll deductions made during active employment. Continuation under COBRA therefore allows an individual to recover any balance in the Health Care Account that was not spent by the termination date.

Continuation Procedure
The procedures for notifying an individual of his or her continuation rights are as follows:

- The Benefits Division will notify an individual of continuation rights within 14 days of termination of employment.

- The individual has 60 calendar days from the date the notice is received to return a signed election form.

- An individual has 45 calendar days from the date the election form is received to pay the first Health Care FSA deposit. That check should cover the period which runs from the employment termination date through the end of the current month.

Each subsequent monthly deposit is due on the first day of the month. However, there is a 31 day monthly grace period to submit deposits. If a deposit is not received by the end of the 31 day grace period, participation will automatically end and cannot be reinstated.

Additional Information

If you have any questions or need further information about the continued coverage provision, please contact the Plan Administrator. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Retirement
An individual may continue to submit FSA claims for reimbursement for services received prior to the date of retirement. An individual may elect to temporarily continue participation in the FSA Health Care Account for expenses incurred after the retirement date. Contributions for this period must be made on an after-tax basis and must be the same monthly amount that was being contributed prior to retirement.

ERISA Rights

Each participant in Los Alamitos Unified School District sponsored benefit plans is entitled to certain rights and protections under the Individual Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports (if any) and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may impose a reasonable charge for the copies.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of individual benefit plans. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including the employer or other person, may terminate an individual's employment or otherwise discriminate against the individual in any way to prevent him or her from obtaining a benefit or exercising his or her rights under ERISA.

If a claim is denied in whole or in part, an individual must receive a written explanation of the reason for the denial. He or she has the right to have the Plan Administrator review and reconsider the claim. Under ERISA, there are steps an individual can take to enforce these rights.

For instance, if an individual requests certain materials from the Plan and does not receive them within 30 days, he or she may file suit. In such a case, the court may require the Plan Administrator to provide the materials and pay the individual up to $100 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
If an individual has a claim for a benefit plan which is denied or ignored, in whole or in part, he or she may file suit. If it should happen that Plan fiduciaries misuse the Plan's money (if benefits ever become funded), or if an individual is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or he or she may file suit. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the person sued to pay these costs and fees.

If an individual loses, the court may order him or her to pay these costs and fees if, for example, it finds the claim frivolous. If an individual has questions about this Plan, he or she should contact the Plan Administrator.

If there are any questions about this statement or about an individual's rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor. The Plan Administrator shall have the maximum authority.

HIPAA PRIVACY PRACTICES, HIPAA SECURITY PRACTICES, STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your participating employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not

sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, 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 Administration, 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.