

HIGLEY UNIFIED SCHOOL DISTRICT
SECTION 125 CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION

July 1, 2005

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**HIGLEY U.S.D.
SECTION 125 CAFETERIA PLAN (“the Plan”)**

SUMMARY PLAN DESCRIPTION

**PART I.
PLAN INFORMATION**

I. INTRODUCTION

1.1. Sponsorship of Cafeteria Plan. Higley U.S.D. (“the Employer”) is pleased to sponsor an employee flexible benefit program for you and your fellow employees. Under Section 125 of the Internal Revenue Code, it is also known as a “cafeteria plan”. It is so-called because it allows you to choose from a menu of different insurance and fringe benefit programs according to your individual needs.

1.2. Overview of Plan Operation. Ordinarily, each dollar of compensation you receive is subject to federal income tax. Each dollar of compensation is also reduced by contributions to Social Security (F.I.C.A.) unless your compensation exceeds the Social Security Wage Base (go to www.ssa.gov and click on questions about earnings and employment to obtain the current years maximum wage). This means that if you wish to purchase one or more of the benefits available under the Plan, you must earn enough compensation to pay *both* the cost of the benefits you elect, *and* the tax and F.I.C.A. imposed on your compensation. Thus, if your combined federal income tax and F.I.C.A. rate is 35%, you must earn \$1.54 before tax to pay for each \$1.00 of these benefits. Even if you work for a state or local government organization where certain employees are exempt from Social Security taxes, you are still subject to the Medicare tax of 1.45% of compensation

Under Section 125 of the Internal Revenue Code, an employer may adopt a cafeteria plan under which eligible employees have the opportunity to choose among taxable cash compensation and certain nontaxable fringe benefits through a salary conversion agreement. If you elect to receive cash, you will be taxed as before. If you elect a nontaxable fringe benefit, each dollar of compensation covered by your election is used to purchase or provide those benefits without reduction for federal income taxes or Social Security contributions.

1.3. Summary Plan Description. This document is a summary of the most important features of the Plan. Since this document cannot contain all of the provisions of the Plan, you may wish to obtain a copy of the Plan. *The provisions of the Plan and its amendments are controlling.* Copies of the Plan are available from your Employer, which may charge a fee for copying the Plan.

The benefits you can purchase through the Plan are separate programs which are subject to the terms of insurance policies, documents or other procedures in addition to this Plan. This Summary does not anticipate the terms of these policies. Your Employer will provide you with additional information or summary plan descriptions describing the features of the insurance policies and other Benefit Programs purchased under this Plan. You may review and make copies of these insurance policies themselves by requesting them from the Employer.

1.4. Definitions and Special Terms. The Plan is a complex legal document which incorporates many words and phrases that have specific meanings. The definitions of these words and phrases are defined in the Plan document. Some of these terms may also be briefly defined in this Summary. However, the actual definition of these terms and phrases as presented in the Plan document are controlling. If you have any questions concerning these terms and phrases, you should consult the Plan document or your Employer.

II. PLAN IDENTIFICATION INFORMATION

Name of Plan	Higley U.S.D. Section 125 Cafeteria Plan
Plan Number	501
Plan Year	July 1 st through June 30th
Adopting Employer	Higley U.S.D. 15201 S. Higley Rd. Higley, AZ 85236 (480) 279-7023
Employer Federal ID Number	86-6000505
Plan Sponsor	Higley U.S.D.
Plan Administrator	Higley U.S.D.
Agent for Service of Legal Process	Higley U.S.D. c/o Superintendent 15201 S. Higley Rd. Higley, AZ 85236
Effective Date of Plan	July 1, 2004
Date of last Amendment and Restatement	July 1, 2005
Summary Plan Description Revision Date	July 1, 2005
Claims Administrator	JEM Resource Partners, LP 4201 Bee Caves Road C101 Austin, TX 78746 Ph: (800) 943-9179 Fax: (888) 989-9247 JEM Website: www.jemtpa.com
Third Party Administrator	JEM Resource Partners, LP

III. ELIGIBILITY AND PARTICIPATION

3.1. Who can participate in the Plan?

To participate in the Plan, an employee must meet the following eligibility criteria:

- a) must be 18 years of age and have completed 1 month of service; and
- b) must work at least 20 hours per week; and
- c) meet the eligibility criteria to participate in one or more of the separate Benefit Programs funded through this Plan.

Those employees who actually participate in the Plan are called "Participants". So long as you remain eligible, you may participate in the Plan until your death, termination of employment, disability, or retirement.

3.2. How do I become a Participant?

On or before the time you become eligible to participate in the Plan, the Plan Administrator will provide you with an enrollment form, on which you may agree to convert a portion of your compensation to Cafeteria Plan Dollars to purchase one or more benefits you elect under the Plan. If you do not initially elect to participate in the Plan, you will be provided a new enrollment form during the Open Enrollment Period which precedes the next Plan Year. In future enrollments, you will be given the opportunity to confirm or change your choices made for the previous Plan Year for the upcoming Plan Year.

3.3. When are the Open Enrollment Periods for entering the Plan?

If you are a new employee, you may initially enroll in the Plan on the first payroll date following the date when you have met the eligibility requirements described in 3.1. above. Thereafter, the Open Enrollment Period will begin on June 1st and end on June 30th. Your Employer may change the Open Enrollment Period from year to year; however, you will be notified each year of the dates.

If you elect to waive participation in the Plan either at your date of hire or at any subsequent enrollment period(s), you forfeit your right to participate in the Plan until the *next* Enrollment Date unless the employee qualifies for a Change in Status described in Answer 8.6 of this Summary Plan Description.

3.4. What are the Enrollment Dates of the Plan?

The Enrollment Date is July 1st.

Newly hired employees who meet the eligibility requirements of 3.1. above, may enroll in the plan on the following dates:

- | | |
|---|------------------------------------|
| ▪ Premium Benefit Programs | 1st of the month following 30 days |
| ▪ Flexible Spending Arrangements | 1st of the month following 30 days |

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

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (FMLA) for periods totaling 12 weeks during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. Of course, you must pay the premiums for the coverage during your absence using one of the following methods:

- *Pre-payment.* Under the pre-payment option, you may (at your option) increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave.
- *Post-payment.* Under the post-payment option, you may have your Employer continue payments for you while you are on FMLA leave, and increase your salary reduction upon your return to work in an amount sufficient to cover the premiums that occurred during your FMLA leave.
- *Pay-as-you-go.* With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid with pretax money as if you had not taken the leave. On the other hand, if

your FMLA leave is unpaid and you choose this option, you will have to reimburse the Employer at regular intervals from your after-tax funds for the premiums that come due during the leave.

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

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will be not interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the plan by paying premiums under any of the two premium payment options described in 3.5 above.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect Continuation Coverage under the Employer's group major medical insurance plan only for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out under that plan.

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

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. You will have until the 90th day after your termination date in which to submit a claim for eligible expenses incurred by you during the time you were covered under the Plan during the current Plan Year. Reimbursements for pre-termination expenses will be limited to the balance of the annual benefit you elected, reduced by any reimbursements you have already received during the Plan Year.

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

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

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below the minimum number of hours required for participation in the Plan (see section 3.1);
- your death;
- divorce or legal separation from your spouse;
- your becoming eligible to receive Medicare benefits; or
- when a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to provide you, and your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs with respect to each health plan in which you are a participant and for which you are qualified to enroll for Continuation Coverage. The notification you will receive will explain all the terms and conditions of Continuation Coverage.

3.9. What is the Grace Period for claims under the Plan?

The Grace Period is a 2.5 month extension immediately following the end of the Plan Year. Participants may submit claims for expenses incurred during this Grace Period if there are unused funds remaining in their flex spending accounts for the Plan Year.

PART II. BENEFITS

The Employer maintains various health and welfare benefit programs. The purpose of the Plan is to allow you to select a combination of certain of these qualified benefits that best suits your needs. The three main groups of benefits provided through this Plan are 1) health and group term-life premium benefit programs; 2) flexible spending arrangements for unreimbursed medical expenses and work-related dependent care; and 3) taxable cash payments in the form of regular salary. The sections in Part II of this Summary describe the benefits which are available through this Plan in detail. The procedures and limitations for allocating your Cafeteria Plan Dollars to the benefits you elect are described in Section VIII. of this Summary.

IV. INSURED PREMIUM BENEFITS

4.1. You will be able to choose to participate in one or more of the following insurance programs by indicating your choice or choices on the benefit enrollment form, and by agreeing to finance your share of the cost by salary conversion (called "Cafeteria Plan Dollars"). The following Premium Benefit Programs are available under various insurance policies maintained by your Employer:

a) Group Health Insurance, including the following:

- Major Medical PPO/HMO Plans
- Dental Plan
- Cancer Insurance
- Accidental Death and Dismemberment (AD&D)

b) Group Term Life Insurance

The specific benefits available under each of these insurance programs will be determined by the insurance policies themselves. These insurance programs or the carriers providing the insurance may vary from year to year. For the details regarding eligibility provisions, benefit amounts, and premium schedules, please refer to the plan summary of each, separate insurance plan that will be provided to you by the Plan Administrator. The Plan Administrator will advise you of the specific terms of the coverage available prior to the time that you must elect whether to apply your Cafeteria Plan Dollars to provide such insurance.

V. MEDICAL EXPENSE REIMBURSEMENT PLAN

One of the more advantageous programs of the Higley U.S.D. Section 125 Cafeteria Plan (the "Plan") is the opportunity for you to elect to receive income tax-free reimbursement for some or all of yours, your spouse's, or your dependents' uninsured medical, dental and vision expenses ("Medical Expenses") under the Flexible Spending Arrangement program known in the Plan as the Medical Expense Reimbursement Plan ("MERP"). Under MERP, you purchase a specific level of medical expense reimbursement benefits, paying for the coverage with Cafeteria Plan Dollars. When you take advantage of this Flexible Spending Arrangement the benefits you elect are nontaxable, and you save social security and income taxes on the amount of the premiums you pay.

Questions & Answers

5.1. Who can participate in the Medical Expense Reimbursement Plan?

Each employee of the Employer who has met the eligibility requirements as defined in Section 3.1 of this Summary.

5.2. How do I become a Participant?

By electing the Medical Expense Reimbursement Plan during the annual Open Enrollment Period.

5.3. What is my “Medical Expense Reimbursement Account”?

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

5.4. What annual benefits are available under MERP, and how much will they cost?

The maximum amount you may convert to Cafeteria Plan Dollars for MERP is \$5000 per Plan Year. You may choose any amount up to this maximum annual benefit. You will be required to pay the annual premium that corresponds to the benefit level you choose. For example, if you elect \$1200 in MERP benefits, you will be required to pay the annual premium of \$1200 through payroll deductions of \$100/month. You should only elect the amount of benefits you feel you will use for the Plan Year.

5.5. How is my Medical Expense Reimbursement benefit paid for?

When you complete the Salary Conversion Election form, you specify the amount of MERP benefits you wish to pay for with your Cafeteria Plan Dollars. Thereafter, you must pay for this benefit by having an equal portion of the annual amount deducted from each paycheck. These amounts are credited to your MERP Account each pay period by your Employer. The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket Medical Expenses at any time during the Plan Year, so long as you continue to be a Participant in MERP.

For example, suppose you elect on July 1st to be reimbursed for up to \$1200 for the year for eligible Medical Expenses, your MERP Account would be credited (funded) by your Employer with a total of \$1200 for the Plan Year. As your election amounts are deducted from your paycheck throughout the Plan Year, your Account would reflect that you have paid \$100 per month for MERP, eventually totaling \$1200 at the end of the Plan Year, less any reimbursements for claims you received during the year.

5.6. What if I have a \$1200 expense early in the Plan Year, is it reimbursable?

Provided that your paycheck continues to be deducted for the periodic premiums due for this benefit, the full, annual amount of coverage of \$1200 you elected on July 1st will be available as a benefit at any time during the Plan Year, reduced by the amount of any prior reimbursements you received earlier in the Plan Year, regardless of the amount you have paid in premiums to MERP.

5.7. How do I receive my benefits under MERP?

If you elect to participate in MERP, you will be issued a flexible spending account debit card, to use to pay for your out-of-pocket medical expenses at the time of service. The debit card automatically transfers your pre-tax dollars from your MERP Account to the provider to pay for your medical expenses. However, only eligible Medical Expenses may be debited from your Account. You should refer to the Claims Administrator’s “*Section 125 Cafeteria Plan Booklet*” on the JEM Website (see Claims Administrator information on page 2) for a list of qualified Medical Expenses before using your debit card.

5.8. What if I forget to use my debit card? Can I still make a paper claim?

Yes, when you incur an expense that is eligible for reimbursement, you may submit a paper claim to the MERP Claims Administrator on the claim form that is provided on the JEM Website. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit you elected. Your debit card expenses and paper claim expenses will be totaled together to determine the total amount of benefit you have used during the Plan Year.

5.9. What is an “eligible Medical Expense?”

For these purposes, an eligible Medical Expense means expenses for medical care which would be deductible for tax purposes if you paid them directly, including all amounts expended for hospital bills, doctor bills, dental and vision bills, prescription drugs, lab work, and other payments for the treatment or cure of disease or for the purpose of affecting any structure or function of the body. Medical Expenses do not include any expenses subject to reimbursement under any health insurance or health plan maintained by the Employer or any other employer or by government programs.

You should review the list of eligible Medical Expenses included with the Claim Form for assistance in determining what is an “eligible expense”, as well as the list provided in the “*Section 125 Cafeteria Plan Booklet*” on the JEM Website. You are also encouraged to consult your personal tax advisor or IRS Publication 502 “Medical and Dental Expenses” for further guidance as to what is or is not an eligible expense if you have any doubts.

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

Eligible expenses must have been incurred during the Plan Year (See Section 3.9). You may not be reimbursed for any expenses arising before the plan became effective, before your MERP election becomes effective, or for any expenses incurred after the close of the Plan Year (See Section 3.9).

5.11. Can I be reimbursed for the full amount of my orthodontia contract?

Generally speaking, if your orthodontia contract covers more than 12 months, you may not be reimbursed for the full amount because Internal Revenue Code regulations require that only expenses *incurred* during the Plan Year may be reimbursed. Because a typical orthodontia contract is for monthly services to be rendered over, for example, a 2 or 3 year period, the amount you can be reimbursed will only be for services which would ordinarily be covered within the 12-month Plan Year.

For example, if the Plan Year is January – December, and your orthodontia contract of \$4500 began in June of this Plan Year for a period of 3 years, your claim for the total orthodontia contract will be paid by dividing the total contract by 36 months and multiplying times the number of months left in the Plan Year. The total you could be reimbursed for this Plan Year in the example below would be \$875.00. You could then submit a claim for \$1500 in the next Plan Year, provided you elect MERP as one of your benefits and you continue to be a Participant in the Medical Expense Reimbursement Plan, and so on in the succeeding Plan Years, until your contract has been reimbursed in full.

Example: \$4500 (total contract) ÷ 36 months (contract period) = \$125.00/month
 \$125.00 x 7 months (June – December) = \$875.00
 \$125.00 x 12 months (January – December of next Plan Year) = \$1500

5.12. What if the medical expenses I incur during the Plan Year are less than the annual benefit I elected?

You will not be entitled to receive any refund of any balance left over in your MERP Account at the end of the 2.5 month Grace Period of the Plan Year. Any balance left at that time is forfeited and may be used by the Employer to pay for any future expenses of the Plan.

5.13. How long do I have to make a claim for reimbursement for eligible expenses?

You have 60 days after the end of the 2.5 month Grace Period of the Plan Year to make any claims for eligible Medical Expenses. After 60 days, any amounts left in your MERP Account will be forfeited. You may look up any remaining balances and claims on your Account on the JEM Website.

5.14. What is “Use it or Lose it”?

You will receive a report of the balance in your MERP Account from the Claims Administrator 60 days prior to the end of the Plan Year. If you do not use up the balance in the account through legitimate eligible Medical Expenses, AND you do not make claim for these expenses within the 60 day period at the end of the Grace Period of the Plan Year (see Answer 5.13), you will lose any amounts left over in your account, i.e., you will forfeit the amounts unused in your MERP Account. See also Answer 5.12.

VI. DEPENDENT CARE ASSISTANCE PLAN

Another major feature of the Higley U.S.D. Section 125 Cafeteria Plan (the “Plan”), is the opportunity for you to elect to receive reimbursement for Dependent Care Expenses under the Flexible Spending Arrangement program known as the Dependent Care Assistance Plan (“DCAP”). Under DCAP, you provide a source of pre-tax funds to reimburse you for your eligible Dependent Care Expenses by purchasing this benefit with your Cafeteria Plan Dollars. When you take advantage of this Flexible Spending Arrangement, the benefits you elect are nontaxable, and you save social security and income taxes on the amount of your salary conversion.

Questions & Answers

6.1. Who can participate in the Dependent Care Assistance Plan?

Each employee of the Employer who has met the eligibility requirements as defined in Section 3.1 of this Summary.

6.2. How do I become a Participant?

By electing DCAP benefits during the annual Open Enrollment Period.

6.3. What is my “Dependent Care Account”?

If you elect DCAP benefits, a Dependent Care Account (“Account”) will be set up in your name to keep a record of the benefits you are entitled to.

6.4. What are the maximum DCAP benefits I may elect?

The Internal Revenue Code limits the amount of benefits you may elect for any Plan Year.

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

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those dependents from whom you are eligible to receive tax-free reimbursements under the DCAP, your spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes.

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

You may elect any benefit amount up to the federal limit allowed for your personal circumstance. You will be required to pay the annual premium that corresponds to the benefit level you choose. For example, if you elect \$2400 in DCAP benefits, you will be required to pay the annual premium of \$2400 through payroll deductions of \$200/month. You should only elect the amount of benefits for the Plan Year you feel you will use.

6.5. How is my Account funded?

When you complete the Salary Conversion Election form, you specify the amount of DCAP benefits for which you wish to pay with your salary reduction (Cafeteria Plan Dollars). Thereafter, your account will be credited with that portion of your gross income you have elected to forego through salary reduction. These portions will be credited as of each pay period.

For example, suppose you elect on July 1st to be reimbursed for \$2,400 per year for eligible Dependent Care Expenses, your Account would be credited (and funded) with a total of \$2,400 during the Plan Year. Thus, if you are paid semi-monthly, you would have a total of \$100.00 credited to your Account each payday to pay benefits under this Plan. The amount that is available in your Account at any particular time will be whatever has been credited to your DCAP Expense Reimbursement Account less any reimbursements.

6.6. What is an eligible Dependent Care Expense?

An eligible Dependent Care Expense is any amount paid or incurred by you or on behalf of you for household services or other expenses directly attributable to the care of a dependent, either inside or outside of your home, in order to enable you to be gainfully employed for any period for which you have a dependent. Dependent Care Expenses include amounts paid for services provided outside your household by a facility such as a day care center that provides care for more than six individuals, but only if the facility complies with all applicable laws and regulations of a state or unit of local government, and the services are provided for the care of a dependent who meets the definition requirements in Answer 6.7. below.

Dependent Care Expenses paid to a family member such as your child under the age of 19, or who is a family member you may claim as a dependent on your personal federal income tax return are not eligible for reimbursement under this Plan.

You should review the list of eligible Dependent Care Expenses included with the Claim Form on the JEM Website (see Claims Administrator information on page 2) for assistance in determining what is an "eligible expense", as well as the list provided in the "*Section 125 Cafeteria Plan Booklet*" on the JEM Website. You are also encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

6.7. Who is an "eligible dependent" for who I can claim a reimbursement?

A dependent eligible under the DCAP Plan must be: (a) a person who is under age 13 and with respect to whom you are entitled to claim an income tax deduction; (b) a parent or other dependent who is physically or mentally incapable of caring for himself or herself; or (c) your spouse, if your spouse is physically or mentally incapable of caring for himself or herself. In the case of clauses (b) or (c), the dependent must spend at least eight hours per day in your household.

6.8. How do I receive my benefits under the DCAP Plan?

If you elect to participate in DCAP, you will be issued a flexible spending account debit card, to use to pay your Dependent Care Expenses at the time of service. The debit card automatically transfers your pre-tax dollars from your DCAP Account to the provider to pay for your expenses. However, only eligible Dependent Care Expenses may be debited from your Account. You should refer to the Claims Administrator's "*Section 125 Cafeteria Plan Booklet*" on the JEM Website for a list of qualified Dependent Care Expenses before using your debit card.

6.9. What if I can't use my debit card? Can I still make a paper claim?

Yes, in the event that you are unable to use a debit card to pay your dependent care provider you may file paper claims. When you incur an expense that is eligible for reimbursement, you may submit a paper claim to the Claims Administrator on the claim form that is provided on the JEM Website. If there are enough credits to your Dependent Care Account, you will be reimbursed for your eligible expenses. Your debit card expenses and paper claim expenses will be totaled together to determine the total amount of benefits you will be eligible to receive.

If your claim is for an amount that is more than your current Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available, annual credits to your Account. You may not be reimbursed for any expenses that arise before your enrollment form becomes effective, or for any expense incurred after the close of the Plan Year (See Section 3.9).

6.10. Will I be taxed on the DCAP benefits I receive?

You will not normally be taxed on your DCAP benefits, up to the limits set out in Answer 6.4. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

6.11. Are there any other limits on what DCAP benefits are tax free?

In addition to the dollar limitations discussed in Answer 6.4., the maximum amount of DCAP benefits you may exclude from income during any calendar year cannot be more than—

- If you are single as of the end of the year, your earned income for the year, or
- If you are married at the end of the year, the **lesser** of your earned income for the year, or your spouse's earned income. If your spouse is a full time student or is disabled, your spouse is considered under the federal tax rules as if he/she has a monthly earned income of \$200 (if DCAP benefits are provided for only one dependent), or \$400 (if DCAP reimbursements are made for two or more dependents.)

6.12. If I participate in the DCAP, will I still be able to claim the household and dependent care credit on my federal income tax return?

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

6.13. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, eligible work-related dependent care expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$2,400 of such expenses for one dependent, or \$4,800 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of \$720 for one dependent or \$1,420 for two or more dependents) to a minimum of 20% of such expenses (producing a maximum credit of \$480 for one dependent or \$960 for two or more dependents). The maximum 30% rate must be reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross incomes over \$10,000.

For example, assume you have one dependent for whom you have incurred eligible expenses of \$3,600, and that your adjusted gross income is \$20,000. Since only one dependent is involved, the credit will be calculated by applying the appropriate percentage to the first \$2,400 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 30% for each \$2,000 of your adjusted gross income over \$10,000. The calculation is: $30\% - [(\$20,000 - 10,000)/\$2,000 \times 1\%] = 25\%$. Thus, your tax credit would be $\$2,400 \times 25\% = \600 . If you had incurred the same expenses for two or more dependents, your credit would have been $\$3,600 \times 25\% = \900 , because the entire expense would have been taken into account, not just the first \$2,400.

6.14. When would I be better off to include the Employer's reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free, and forego the credit reimbursements under the DCAP?

Generally, if your income tax bracket is 15% or less, you will probably come out ahead by including the DCAP benefits in income, and claiming the credits for dependent care and earned income. On the other hand, it will generally be better to treat DCAP benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits. A worksheet is available on the JEM Website to help you make the necessary calculations; you should consult your tax adviser if you need assistance using the calculation worksheet.

6.15. What if the DCAP expenses I incur during the Plan Year are less than the annual benefit I elected?

You will not be entitled to receive any refund of any balance left over in your DCAP Account at the end of the Plan Year. Any balance left at the end of the 2.5 month Grace Period of the Plan Year is forfeited and may be used by the Employer to pay for any future expenses of the Plan.

6.16. How long do I have to make a claim for reimbursement for eligible Dependent Care Expenses?

You have 60 days after the end of the 2.5 month Grace Period of the Plan Year to make any claims for eligible DCAP Expenses. After 60 days, any amounts left in your DCAP Account will be forfeited. You may look up any remaining balances and claims on your Account on the JEM Website.

6.17. What is "Use it or Lose it"?

You will receive a report of the balance in your DCAP Account from the Claims Administrator 60 days prior to the end of the Plan Year. If you do not use up the balance in the account through legitimate eligible Dependent Care Expenses, AND you do not make claim for these expenses within the 90 day period at the end of the Plan Year (see Answer 6.16), you will lose any amounts left over in your account, i.e., you will forfeit the amounts unused in your DCAP Account. See also Answer 6.15.

VII. CASH BENEFITS

Under Internal Revenue Code regulations, a cafeteria plan will not be qualified unless your Employer offers you the choice of cash, a taxable benefit, and nontaxable benefits such as those provided in the previous sections. When you complete a Salary Conversion Election form, you are choosing between cash and those benefits you elect by converting a portion of your pay to Cafeteria Plan Dollars to purchase one or more nontaxable benefits. Any part of the maximum Annual Benefit Limit defined in Section 8.5. that you do not choose to apply toward the purchase of the nontaxable benefits described below will be deemed as being elected by you to be received as regular, taxable salary.

Questions & Answers

7.1. Can I choose all cash compensation and no fringe benefits?

Yes, under the Salary Conversion Election form, you are offered the opportunity to waive your right to any of the nontaxable benefits. In that case, you will receive that portion of the Annual Benefit Limit provided to you in your wages as taxable income.

7.2. Do I have to choose any cash? May I elect to receive the total benefit limit in fringe benefits?

No, you do not have to choose any amount of the maximum Annual Benefit Limit as cash. You may apply the maximum Annual Benefit Limit towards the purchase of all nontaxable fringe benefits.

VIII. CONTRIBUTION AND ELECTION LIMITATIONS

8.1. What are "Cafeteria Plan Dollars"?

For each Plan Year, you may elect to convert a portion of your Compensation, called salary conversion, to purchase various benefits covered by the Plan. Your salary conversion contribution is called your "Cafeteria Plan Dollars." Only Cafeteria Plan Dollars may be used to purchase benefits available under the Plan.

8.2. Is my overtime pay subject to salary conversion?

Under the Plan, any Compensation you receive for overtime, vacation or other paid leave time, bonuses, commissions, as well as your regular salary or wages is subject to conversion to Cafeteria Plan Dollars as necessary in order to meet the monthly premium amounts due for the benefits you elected.

8.3. What if I am a retiring teacher or terminating employment, is my contract pay subject to salary conversion?

If you are a contracted employee retiring or otherwise terminating employment at the end of your contract period, for example, August 1- July 31, and you elect to receive a lump sum payment (assuming your Employer allows this election) through the end of your contract on your last day of work (for example, pay due for May 1-July 31 paid on last day of work, May 31) this payment would be considered part of your regular salary, even though it is paid in a lump sum prior to the end of your contract. Any amounts due for the remainder of the contract period could be converted to pay for that period's monthly premiums,

assuming you want to continue coverage under the Plan, AND *you don't effectively terminate your employment until the last day of your contract*. If you effectively terminate your employment on May 31, then you cease to be a participant in the Plan on June 1, and your benefit premiums could not be paid with your Cafeteria Plan Dollars through August 31, even if paid in a lump sum on the last day of work.

8.4. Is a bona-fide severance package subject to salary conversion?

No, a bona-fide severance package would not be considered part of your regular pay, but rather a separate unemployment welfare benefit plan provided by the Employer. Once you terminate employment, you are no longer eligible to be a participant in the Plan; therefore any severance paid to you, that is, any pay made to you under the Employer's unemployment welfare benefit plan, may not take advantage of the pretax salary conversion feature of the Plan. However, if your Employer allows it, you may want to make arrangements with the Plan Administrator to make Continuation Coverage payments from your severance pay.

8.5. What is the maximum Annual Benefit Limit?

The maximum Annual Benefit Limit is the maximum amount of Employer contributions available to any participant in the Plan which may be converted to Cafeteria Plan Dollars and must equal the total amount of the annual premiums anticipated for all benefits in the Plan.

The maximum amount of Cafeteria Plan Dollars which may be allocated to Insurance Premium Benefits is the cost of the premium rates from year to year of the most expensive benefits available to you in each Premium Benefit Program Option under the Plan. If the amount of the premium for insurance increases or decreases during the Plan Year, your Salary Conversion Election may be adjusted accordingly.

The maximum amount of Cafeteria Plan Dollars which may be allocated to Flexible Spending Arrangement benefits are limited as follows:

- | | |
|--------------------------------------|----------------------|
| ▪ Medical Expense Reimbursement Plan | \$5,000 |
| ▪ Dependent Care Assistance Plan | \$5,000 ¹ |

8.6. Can I change my elections during the Plan Year?

Once you elect to apply Cafeteria Plan Dollars to the purchase of benefits under the Plan, generally you cannot change your election whether or not to participate in the Plan, or vary the benefits you have selected, during the Plan Year. Except as noted below, you may revoke or modify an election only during the annual Open Enrollment Period which precedes each Plan Year.

There are important exceptions to this general rule:

If you elected health insurance coverage or group-term life insurance benefits, you will be able to revoke this previous election and make a new election if:

- (only with regard to your health insurance election) you, your spouse, or one of your covered dependents becomes covered by the employer's group health plan as a special enrollee under Code Sec. 9801(f). (The Administrator of the group health insurance plan will furnish you with information as to the special enrollment rights that employees and their dependents have with regard to entry into the health insurance plan at nonstandard enrollment times.)
- your legal marital status changes through marriage, death of your spouse, divorce, legal separation, or annulment;
- the number of dependents you have for federal income tax purposes changes due to birth, adoption, placement for adoption, or death;
- you, your spouse, or any other dependent, begins or ends employment;

¹ \$2,500 if you are a married individual filing a separate return. This dollar limit is stipulated by the Internal Revenue Service; please refer to Answer 6.4.

- you, your spouse, or a dependent experiences a reduction or increase in hours of employment, including a switch between part-time and full-time, a strike or lockout, or beginning or end of an unpaid leave of absence;
- a dependent of yours satisfies or no longer satisfies the requirements for health insurance coverage due to attainment of age, student status, or any similar circumstance as provided in the accident or health plan under which you are covered as an employee; and
- you, your spouse, or any of your dependents changes the place of residence or work.

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

Likewise, a previous election of group-term life insurance coverage paid for through this Plan may be revoked and replaced with another election regarding this coverage only if: (1) in the case of marriage, birth, adoption, or placement for adoption, you elect to *increase* (but not reduce) the amount of your life insurance coverage (subject to the Plan limitations); and (2) in the case of divorce, legal separation, annulment, or death of a spouse or dependent, you elect to *reduce* (but not increase) the amount of your life insurance coverage.

You may change or revoke your previous election on benefits *other than* health insurance coverage or group-term life insurance coverage at any time during the Plan Year and make a new election if there is one or more of the following Change in Status rules--

- your marriage or divorce;
- birth or adoption of your child;
- death of your spouse or child;
- a significant change in the medical benefits or premiums available either to you, through your employment with the Employer, or to your spouse, through his employer. If you otherwise are entitled to revoke an election or make an alternate election by reason of an increase in health insurance costs, you must do so within 30 days of receipt of written notice from the Plan Administrator of the significant change in cost or composition of the benefit originally elected; or
- termination of your employment, your spouse's employment, or change of either your or your spouse's employment status from full-time to part-time, or vice versa, or if either of you take an unpaid leave of absence from work.

If one of these qualifying Change in Status rules occurs, you must inform the Plan Administrator of your new election **within 30 days of the occurrence**. Failure to do so within the 30-day period will result in the changes in your election being applicable only to months during which, or after, you have notified the Plan Administrator.

8.7. Can I drop my election if I take a family or medical leave?

You may revoke any election you made for the period during which you are absent from work for a family medical leave covered by the federal Family and Medical Leave Act (FMLA). You may reinstate your election of group medical benefits when you return from the FMLA leave. However, you may not reinstate a revoked election as to any nonhealth insurance benefits until the next regular Enrollment Period.

8.8. What if the insurance company changes the premium in the middle of the year and I can no longer afford the health insurance?

If there is a significant change in cost of an elected benefit, you may change or drop your election if you could no longer afford the premium increase. Similarly, if you had not elected a health benefit because of the cost, and the premium dropped significantly enough for you to afford it, or your employment status changed from part-time to full-time, you may elect to begin participation in a program you were not previously signed up for before the next Enrollment Period. The change in cost rules are not applicable to

the Medical Expense Reimbursement Plan, or a cost increase imposed by a dependent care provider who is a family member.

8.9. What if my employer changes the benefit packages in the middle of the year, can I change to a better plan?

If a significant change in coverage occurs which improves a benefit package option, you will be permitted to revoke your current election and enroll under the new or improved benefit package option. However, if there is a significant change in coverage of an elected benefit which decreases the amount of coverage you had, you may only drop your current coverage if you elect coverage under another similar benefit package option.

8.10. What if I need to use Continuation Coverage under COBRA, may I change my election?

If you, your, spouse, or any dependent becomes eligible for COBRA Continuation Coverage under the Employer's Group Health Coverage as provided in Code Sec. 4980B² or any similar state or federal law (such as PHSA), you may elect to increase payments under this Plan under the change in cost rules noted above (8.8) in order to pay for Continuation Coverage. However, you will not be allowed to make any *election* changes until the next Enrollment Period, unless the changes are for reasons covered under Change in Status, cost or coverage rules above.

² Group Health Coverage shall be defined in accordance with the COBRA regulations amended February 3, 1999 for Plan Years beginning on or after January 1, 2000, and may or may not include health Flexible Spending Arrangements based on the facts and circumstances of the Qualified Beneficiary.

PART III. ADMINISTRATION OF THE PLAN

IX. ADMINISTRATION OF ACCOUNTS

The Plan is administered by the Employer, which is the Plan Administrator and the fiduciary of the Plan for these purposes.

9.1. What are my “Cafeteria Plan Accounts”?

If you elect benefits under the Plan, one or more Cafeteria Plan Accounts (“Accounts”) will be set up in your name to keep a record of each benefit you are entitled to. How many accounts are established depends on which benefits you elect. For example, if you choose to participate in the Medical Expense Reimbursement Plan, the Dependent Care Assistance Plan, and in one or more of the Insurance Plans, three accounts will be maintained in your name.

9.2. How are my Accounts funded?

When you complete the enrollment form, you specify which benefits you wish to pay for through salary conversion. Thereafter, your accounts will be credited with that portion of your gross income you elect to forego through salary conversion. These portions will be credited as of each pay period. For example, suppose you elect the following:

Benefit Elected	Annual Cost
Group Medical Insurance	\$ 750.00
Medical Expense Reimbursement Plan	1,000.00
Dependent Care Assistance Plan	<u>2,000.00</u>
Total Annual Cost	\$3,750.00

Assuming you are paid semi-monthly, the cost of the above benefits per paycheck would be \$156.25. Your Accounts would be credited with a tax-free total of \$3,750.00, spread equally over 24 paychecks, or \$312.50 per month. Thus, each pay period, your accounts would be credited as follows:

Dependent Group Medical Insurance	\$31.25
Medical Expense Reimbursement Plan	41.67
Dependent Care Assistance Plan	<u>83.33</u>
Total Credited per Pay Period	\$156.25

The total amounts that may be credited to your account during any one Plan Year will be limited to the Annual Benefit Limit in Answer 8.5. The amount that is available in any one of your Accounts at any particular time will depend on the benefits you elect. Premium benefit accounts are current in nature, and the Employer will pay out amounts you have set aside for insurance benefits as they become due to the insurance company or companies. If you elect Medical Expense Reimbursement benefits, your corresponding benefit Account will be credited to reflect the premiums you were paid, although the full, annual amount of the benefit will at all times be available to you (less previous benefits). If you choose to participate in the Dependent Care Assistance Plan, your corresponding benefit Account will be credited with the amount you set aside from each paycheck, and will accumulate until you submit a documented claim for reimbursement of eligible expenses.

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

The money you set aside as payment for reimbursement of your Medical Expenses, or for reimbursement of your work-related Dependent Care Expenses, will be segregated by the Employer into a fund as soon as is administratively possible after an amount has been deducted from your paycheck. Payroll

deductions for insurance premiums will be currently forwarded to the respective insurance companies as the premiums become payable, normally monthly.

9.4. Will my Accounts earn any interest?

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

9.5. Will I have to pay any Plan administration fees?

No, your employer pays all flex spending administration fees.

9.6. May I withdraw cash from any of my Accounts?

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

9.7. May I shift amounts from one Account to another?

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

X. CLAIMS ADMINISTRATION

10.1. How do I receive my benefits under the Plan?

Generally, you will file a claim with the insurance company or third party hired by the Employer to handle your claims (“Claims Administrator”) on claims forms that are provided for this purpose.

A. Premium Option Plans. If Benefits under the Plan are provided through insurance, your claims will be processed under the procedures and filing deadlines provided under the insurance policies involved. To appeal the denial of a claim under these Benefit policies, refer to the summary booklets pertaining to each Benefit Program.

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

In the event the insurance carrier increases the premiums of your benefit in the middle of the Plan Year, the Employer reserves the right to increase your payroll deduction for that benefit accordingly. You will be notified as soon as possible regarding the increased premium payments and you will be given an opportunity to make adjustments to your benefit choices or amounts if the cost increase is significant and the subsequent changes would be allowed by the IRS (see Answer 8.8).

B. Flexible Spending Accounts. If Benefits are not provided through insurance, for example, vision care expenses or orthodontics work, you may apply to the Claims Administrator against your Flexible Spending Accounts when you believe you are entitled to payment, or you may use your debit card. (See 10.3 below) No benefit will be distributed from your Flexible Spending Accounts by the Claims Administrator until an application for benefit claim is filed. A written statement from an independent third party stating that the expense has been incurred and the amount of such expense must be submitted. Claims applications must be filed within 60 days after the end of the 2.5 month Grace Period of the Plan Year for expenses incurred during the prior Plan Year.

If you elected to participate in either the Medical Expense Reimbursement Plan or the Dependent Care Assistance Plan, and you did not use your debit card, you will have to take certain steps to be reimbursed for your eligible expenses. When you incur an expense that is eligible for payment out of one of your Accounts, you submit a claim to the Claims Administrator on a claim form which is found at the JEM Website. See Section V of this Summary for a description of the reimbursement procedures that apply to Medical Expenses, and Section VI for an explanation of the requirements for reimbursement under the

Dependent Care Assistance Plan. You may not be reimbursed for any expenses with respect to the current year of your participation that incurs before the Plan becomes effective, before your enrollment form becomes effective, or for any expenses incurred after the close of the 2.5 month Grace Period of the Plan Year.

Review the list of eligible expenses included with the Claims Form for assistance in determining what is an “eligible expense,” as well as the list provided on the JEM Website under “*Section 125 Cafeteria Plan Booklet*.” You are also encouraged to consult your personal tax advisor or IRS Publication 17 “Your Federal Income Tax” for further guidance as to what is or is not an eligible expense if you have any doubts.

10.2. When do I submit my claims?

You may submit your claims at any time by mail or by fax to the Claims Administrator to the address or fax number on the Claim Form. Generally, claims and checks are processed twice a week. In addition, you will have 60 days after the end of the Grace Period of the Plan Year in which to submit a claim for reimbursement for eligible expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

10.3. How does the debit card work?

Your Employer provides a unique claims process which cuts down on most paper claim forms by utilizing the JEM debit card system. You may use your debit card to pay for your out-of-pocket medical and dependent care expenses at the time of service. In general, the debit card works like an ATM card by automatically debiting your MERP or DCAP Account and transferring your pre-tax dollars to the provider to pay your expenses. However, just like any other form of debit card, the provider has to be set up to use the JEM debit card system and must follow certain guidelines for providing a claims “paper trail.” This keeps you from having to turn in any claims paperwork. However, you should always keep copies of all your debit card claims receipts in case there is any need for proof of claims from the Claims Administrator. The Claims Administrator has the right to request claims receipts at any time. Should you fail to produce these receipts, your debit card may be inactivated or revoked.

Only eligible expenses may be debited from your Account. The provider must use expense codes which are set up in the debit card system. If the wrong expense code is entered (for example, unqualified over the counter drugs at the pharmacy, or cosmetic procedures at your dermatologist), your attempt to use your debit card for this expense will be denied. You should refer to the Claims Administrator’s “*Section 125 Cafeteria Plan Booklet*” at the JEM Website for a list of qualified expenses before using your debit card.

Additionally, your expense cannot be for more than the amount funded to your MERP or DCAP Account. For example, if you try to pay a \$100 hospital co-pay at the end of the Plan Year, and you only have \$89 left in your MERP Account, your debit card will deny the entire \$100 claim. In this example, your provider should enter \$89 as your co-pay (minus any per transaction fee that may be applicable) and you will have to pay the remainder out-of-pocket, or you can file a manual claim.

The claims administration rules in this Section X will apply to debit cards where applicable.

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

No. Any amounts remaining in your Cafeteria Plan Account at the end of a Plan Year which are not used to purchase Benefits or reimburse expenses incurred during the Plan Year will be forfeited per IRS regulations. You will have 60 days after the Grace Period of the Plan Year ends to submit claims for reimbursement.

10.5. Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are not currently taxable to you under present law. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser.

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

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

XI. PLAN AMENDMENT AND TERMINATION

11.1. How long will the Plan remain in effect?

The Employer intends that the Plan will be a permanent program to benefit Employees. However, the Employer reserves the right to amend or terminate the Plan at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly. Any such amendment or termination may be complete or partial and may be made retroactive to the extent allowed by law, but neither action will deprive you of any benefits to which you have previously become entitled. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the Plan Year in which termination occurs (See Section 3.9).

11.2 What is a Summary of Material Modifications?

Periodically, you may receive a copy of a Summary of Material Modifications (SMM). Like this Summary Plan Description, a Summary of Material Modifications summarizes the effect of any amendments made to the Plan. You should keep any SMMs you receive as "amendments" to this Summary Plan Description.

XII. QUALIFICATION OF PLAN AND RELATED MATTERS

The Plan is intended to be a "cafeteria plan" under Section 125 of the Internal Revenue Code and the description of the Plan in this summary is based on the assumption that the Plan does so qualify. However, neither the Employer, the Plan Administrator, nor any other agent of the Employer or the Plan represents or guarantees that the Plan will be so qualified at any time, nor is the Employer obligated to amend any aspect of the Plan which results in failure to meet the requirements of the Internal Revenue Code. The failure of the Plan to qualify under the Code could result in significant and adverse tax consequences to Participants in the Plan. For each Plan Year, you may elect to convert a portion of your Compensation to "Cafeteria Plan Dollars." Your taxable Compensation will be reduced to the extent of your election. Only Cafeteria Plan Dollars may be used to purchase Benefits available under the Plan.

The Plan Administrator will provide an enrollment and election form to each Employee who is eligible to participate in the Plan. Your election will not be effective unless your form is returned to the Plan Administrator prior to the close of the Open Enrollment Period which precedes your elections beginning under the Plan. Your election will continue until you change or discontinue it or become ineligible to participate in the Plan.