SUMMARY PLAN DESCRIPTION

for the

Meade School District 46-1

Group #02662

Flexible Benefits Plan

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Flexible Benefits Plan

Dear Participant:

Your Employer has adopted a Flexible Benefits Plan for the exclusive benefit of you and all participating Employees. Its purpose is to reward you for loyal service by enabling you to select certain employee benefits that will best fit your individual needs in a tax-effective manner. If you elect to use the benefits of the Flexible Benefits Plan, you may realize savings of income taxes and Social Security taxes. Your Employer has established this Plan with the intention that it will be continued indefinitely, but the Employer does reserve the right to amend or terminate this Plan at any time.

The Plan is a written document which sets forth the provisions of this fringe benefit program. In order to find out how the program affects you and your family, you may read the actual document (copies are available to you at the offices of your Employer and the Plan Administrator during regular business hours). However, to help you understand this program, we have condensed your Plan into a summary which explains the provisions and benefits available under the program.

This summary is not meant to interpret, extend or change the Plan in any way. In case of a conflict between this summary and the actual provisions of the Plan, the provisions of the Plan will govern your rights and benefits.

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1) GENERAL INFORMATION

How To Participate in Your Flexible Benefits Plan

If you are an eligible Employee, election and agreement forms will be provided by your Employer along with information to allow you to make an election regarding your Flexible Benefit options.

First Plan Year: If you are eligible to participate at the beginning of the first Plan Year, your Employer will provide you with information for making your election under the Plan, including any deadlines.

Subsequent Plan Years: After the first Plan Year, your Employer will designate a period during which you may elect options under the Plan. You will receive advance notice of this election period from your Employer.

Eligible After the Beginning of a Plan Year: If you are a new Employee (or a current Employee who becomes eligible after the beginning of a Plan Year), your Employer will provide you with information regarding elections, including any deadlines.

You must complete and return the election form to your Employer prior to the end of the election period designated by your Employer. If in the year in which you first become eligible to participate, you fail to complete and return the election form to your Employer on or before the date specified, you will be deemed to have elected not to participate in noncash benefits under the Plan. Once enrolled, elections made for Pre-tax Premium Options (see page 6) will remain in effect from year to year unless changed or revoked. You will, however, be given an opportunity to make new elections prior to the start of each new Plan Year. Coverage under a Reimbursement Account requires a new election prior to the beginning of each Plan Year.

Once you make an election, your decision is in effect throughout the Plan Year, unless a modification is made under the provision described below under the heading "Changes in Plan Election."

In addition to your contributions, your Employer may, under certain circumstances, contribute to the Plan for your benefit. Your Employer will advise you of its contribution, if any, prior to the beginning of a Plan Year.

Selection of tax-free benefit options under the Flexible Benefits Plan will normally result in your Employer and yourself making lower contributions to the federal Social Security system. This will reduce your Social Security contributions and could reduce your Social Security benefits. Any contributions that are not used to pay for benefits you select will be forfeited to your Employer. Because this is possible, you should be careful to authorize only those amounts necessary to pay for the coverage you need.

Effective Dates

If you elect noncash benefits under your Flexible Benefits Plan, your election will be effective as follows:

First Plan Year: An eligible Employee who is employed on the Effective Date and who makes an election prior to that date will become a participant on the Effective Date.

Subsequent Plan Years: Elections made during the annual election period of subsequent Plan Years will become effective at the beginning of the next Plan Year.

After Beginning of Plan Year: An Employee who becomes eligible after the beginning of a Plan Year will have 31 days to elect to participate in a noncash benefit option under the Plan. An Employee who meets the eligibility requirements after the Effective Date may become a Participant

- ☐ On the first of the month following the date of hire.
- ☐ On the first day of the first payroll period following the date on which the Employee meets the eligibility requirements of the Plan.
- ☐ On the first day of the first month following the date on which the Employee meets the eligibility requirements of the Plan.
- ☐ following the date on which the Employee meets the eligibility requirements of the Plan.
- ☐ Immediately on the date on which the Employee meets the eligibility requirements of the Plan.
- ☒ Other: Teachers – eligible 1st day of employment
  All other employees – 1st of the month after 90 days.

The election will be effective following receipt of a completed election form.

Termination: An Employee who terminates employment is considered terminated on: Date of termination for staff and August for Teachers.

Changes in Plan Election

As a general rule, your election for benefits under the Plan may not be changed during the Plan Year. However, under certain circumstances you may be able to modify your election during the Plan Year if a Change in Status occurs. A Change in Status includes:

* Change in Employee marital status;
* Change in residence or worksite of Employee, spouse or Dependent (if benefit eligibility or dependent care expenses are affected);
* Change in number of Employee's Dependents;
* Employee, or spouse or Dependent becoming eligible for, and participating in, Medicare or Medicaid;
* Change in employment status of Employee, spouse or Dependent;
* A Dependent first satisfying (or ceasing to satisfy) the requirements for coverage

You may also modify your benefit election (except your election with respect to the Medical Expense Reimbursement Account) in the event of significant changes in plan costs or coverages or in the event of the addition or elimination of a benefit package option or a coverage change made under a plan sponsored by the Employer or by the employer of your spouse or Dependent. For insignificant cost increases or decreases to your portion (employee portion) of the cost of benefits during the Plan Year, the Employer will automatically adjust your election to reflect the increase or decrease.

If a judgment, decree, or order ("Order") from a divorce, separation, annulment, or custody change (including a Qualified Medical Child Support Order) requires your child, including a foster child who is your Dependent, to be covered under the Employer's group medical plan or Medical Expense Reimbursement Account, you may change your election to provide coverage for the child. If the Order requires another individual, such as your spouse or ex-spouse, to cover the child, then you may change your election to revoke coverage for the child, provided that coverage, is, in fact, provided for the child.

Any modification of an election must be consistent with the change which allows the modification to be made, may not reduce a Medical Expense Reimbursement election below the amount of benefit used as of the election change, and must be completed and returned to your Employer within 30 days of the event permitting the change.

You may also revoke your election and make a new election if you, your spouse and/or Dependent(s) qualify for special enrollment under a health plan. Under the Health Insurance Portability and Accountability Act, group health plans are generally required to permit individuals to be specially enrolled for coverage following a loss of other health coverage or when a person becomes the spouse or dependent of an employee through birth, marriage, adoption or placement for adoption. In addition, you may revoke your election and make a new election if you, your spouse and/or Dependent(s) cease to be eligible for Medicaid or State Children's Health Insurance Program (SCHIP) coverage or become newly eligible for premium assistance under Medicaid or SCHIP. For purposes of Medicaid and SCHIP events only, the new election must be made within 60 days of the termination of coverage or eligibility for premium assistance.

Notwithstanding the foregoing, please note that you may not change from a Limited Purpose Medical Expense Reimbursement Account to a General Purpose Medical Expense Reimbursement Account for any reason during a Plan Year. (See the "Medical Expense Reimbursement Account" section below.) (Please note that you may not switch from a General Purpose Account to a Limited Purpose Account at any time other than effective with the first day of the month following the end of the Grace Period.)

Your Employer reserves the right to limit your elections under the Plan if necessary to meet the nondiscrimination requirements of the law.

Any new election you make will be effective on the date prescribed by your Employer, but generally not earlier than the first pay period beginning after the election form is completed and returned to your Employer.

If you cease to be a participant in the Plan during a Plan year, you may not re-elect coverage for the remaining portion of the Plan year other than due to a Change in Status. If you resume employment with the Employer within 30 days of terminating employment, your Compensation Reduction Election in effect at the time of your termination of employment will be automatically reinstated. If you resume employment with the Employer more than 30 days following termination of employment, you may re-elect coverage for the remaining portion of the Plan Year.

Leave of Absence

If you take a leave of absence due to disability, family or medical leave, or any other reason approved by your Employer, you shall have the option to:

a) Revoke or change your Compensation Reduction Election based on a Change in Status.

b) Prepay, on a pre-tax or after-tax basis, all or a portion of the Flexible Dollar amounts that would normally have been contributed during the period of time you expect to be on leave. You may allocate the prepayment amount to provide increased, decreased or different benefits as specified on your Prepayment Election form. In no event will a change in your election affect the amount of your Employer's share of the cost of benefits selected. In fact, a full or complete reduction in the amount of Flexible Dollars allocated toward a benefit will result in a corresponding reduction in the benefit itself, except in certain circumstances where the unpaid leave is taken pursuant to the federal Family and Medical Leave Act ("FMLA").

c) Continue to pay, on a pre-tax or an after-tax basis, the Flexible Dollar amounts, at the same rate and in the same manner as you were prior to your leave (i.e. every payroll period). If your payment is more than thirty (30) days late, the Employer may drop your coverage or may continue to pay for your share of the coverage at the Employer's discretion. However, your Employer may recover from you the cost of any payouts made to maintain your coverage unless you do not return to work and such failure to return to work is a result of circumstances beyond your control.

During unpaid leave, you have the right to revoke or change your Compensation Reduction Election under the same terms and conditions that apply to Participants who are not on leave.

Upon return from unpaid leave, your original Compensation Reduction Election will recommence for the duration of the Plan Year except for a Change in Status described under the heading “Changes in Plan Election” or upon the occurrence of one of the other events described under that heading.

Regardless of the payment option selected, as long as you continue to make contributions to the Plan, the full amount of coverage elected under the Medical Expense Reimbursement portion of the Plan, less any permitted reduction and less any prior reimbursements, will be available to you at all times, including during an unpaid FMLA leave period. However, if you cease to make contributions so that your coverage under this portion of the Plan terminates while on leave, you are not entitled to receive reimbursement for claims incurred during the period when the coverage was terminated.

If you elect to reinstate coverage (or your Employer requires reinstatement of coverage) upon return from leave, you may elect to either resume coverage under this portion of the Plan for the remainder of the Plan Year in an amount equal to the original Compensation Reduction Election for the 12-month period of coverage provided that you make up any unpaid premium payments, or you may elect to resume coverage in an amount equal to your original Compensation Reduction Election for the 12-month period of coverage prorated for the period when coverage was terminated during leave. In either case, the coverage will be reduced by prior reimbursements.

Medical Child Support Order

Upon receipt of a medical child support order, your Employer will determine, in accordance with a written and established procedure, whether the order is qualified. If the order is found to be a Qualified Medical Child Support Order, the Plan will provide medical coverage to your child without regard to Plan limitations which may require that you have custody of the child or that the child be designated as your dependent for tax purposes. The child will have medical coverage as of the date of the order, not limited or delayed for either a pre-existing condition or a waiting period. Reimbursements of benefit payments will be made to the child or the child's custodial parent. A Qualified Medical Child Support Order is an exception to the general rule that your benefits under the Plan cannot be assigned or alienated.

HIPAA Privacy

In administering and maintaining the Medical Expense Reimbursement Account portion of the Plan, certain people may have access to private health information about you. To the extent required by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), your Employer is required to adopt and follow policies and procedures to protect your private health information received or created by the Plan and limit its use and disclosure. If you have any questions about HIPAA, or the Plan's or your Employer's obligation in this regard, you should contact your Employer's personnel or human resources manager.

Termination Dates

Your benefits under the Plan will terminate on the earliest of:

- the date you cease making contributions to the Plan; or
- the date the Plan terminates; or
- the date you cease to be an eligible Employee; or
- the date you cease to belong to a class for which benefits are made available; or
- as to any specific coverage or benefit, the date it is discontinued.

However, you may be eligible to continue to file claims for reimbursement. See the sections entitled "Reimbursement" and "Reimbursement After Termination of Employment." Furthermore, you may be eligible for a special continuation option under the Plan. See the section titled "Reimbursement After Termination of Employment."

Benefits of Participation

Your benefit of Participating in the Flexible Benefit Plan can best be shown by the following example:

John and Jane Jones are married and have two children. John earns $26,000 a year.

John decides to enroll in the Flexible Benefits Plan. He elects to contribute $1,500 ($125 a month) of his current compensation into the Plan to purchase benefits which he would otherwise buy with after-tax dollars.

With the Plan, John is able to pay for the benefits with the dollars that are not taxed. A comparison of John's disposable income with and without the Plan follows:

Savings Example	**With Flexible Benefits**	**Without Flexible Benefits**
Gross Salary	$26,000	$26,000
Pre-tax compensation used to purchase benefits	$1,500	$0
Taxable salary	$24,500	$26,000
Federal income tax	$3,079	$3,304
Social Security tax	$1,874	$1,989
Total taxes	$4,953	$5,293
Salary after taxes	$19,547	$20,707
After-tax cost of benefits	$0	($1,500)
SPENDABLE INCOME	$19,547	$19,207

NET SAVINGS <u>WITH</u> PLAN = $340

John Jones receives $340 ($19,547 minus $19,207) more per year in spendable income if he elects to pay for his benefits through the Plan.

2) DESCRIPTION OF BENEFITS

Pre-tax Premium Payment Option

The Pre-Tax Premium Payment Option allows you to use tax-free dollars to pay your share of the health care premiums under your Employer's group medical plan(s), as well as your premiums under any of the other plans of your Employer providing the benefits listed in the Plan Administration Information Supplement at the end of this Summary. After electing this benefit your relevant premium contributions will be taken from your pay before certain taxes are deducted. Your Employer will then pay your contribution amounts as premiums to the relevant plan.

Reimbursement Accounts

You may elect to participate in the following reimbursement account options:

Option 1: Medical Expense Reimbursement Account

Option 2: Dependent Care Expense Reimbursement Account

Each Plan Year, you may elect one or both types of reimbursement accounts. You will need to decide when completing your election form prior to the beginning of each Plan Year how much contribution from each pay period, if any, goes to each reimbursement account.

Your account will reimburse you only for eligible expenses incurred during the Plan Year (or during the Grace Period as explained in How To File For Reimbursement From Reimbursement Accounts) and while you are participating in the Flexible Benefit Plan. When you incur a qualifying expense, you will need to submit a Request for Reimbursement form (see How To File For Reimbursement From Reimbursement Accounts) along with documentation of the expense.

Expenses reimbursed under the reimbursement account options are not eligible as a deduction or credit for income tax purposes. In addition, they cannot be reimbursed under any other type of benefit plan.

The maximum amount you may contribute to each of these options is described in the Plan Administration Information Supplement at the end of this Summary. The amount you elect to contribute to each option will be deducted from your pay in equal installments throughout the year.

Medical Expense Reimbursement Account

The Medical Expense Reimbursement Account enables you to pay for qualified medical care expenses with pre-tax Flexible Dollars. There are two types of Medical Expense Reimbursement Accounts under the Plan: a **General Purpose Account** and a **Limited Purpose Account** if you, your spouse or Dependent make or receive contributions in a Health Savings Account ("HSA"). You may only participate in one type of Medical Expense Reimbursement Account. In a General Purpose Account, qualified medical care expenses mean certain medical, vision, and dental care expenses incurred by you, your spouse, and your Dependents for medical care (as defined in Section 213(d) of the Internal Revenue Code ("Code")). In a Limited Purpose Account, qualified medical expense means certain vision and dental expenses incurred by you, your spouse or your Dependents for medical care (as defined in Section 213(d) of the Code).

With respect to medical expense reimbursement, your Dependent means any individual who is your dependent as defined in Code Section 152, as the definition is modified by Code Section 105 (in general, your qualifying children and qualifying relatives, regardless of their marital status, whether they have their own dependents and even if they earn more than the current dependent exemption amount).

In a **General Purpose Account**, qualified medical care expenses include charges incurred for the following, if not otherwise paid by any other plan (this list is not exhaustive):

- deductibles and co-payments;
- excess hospital room and board charges, such as the difference between a semiprivate room and a private room;
- physical exams;
- drugs and medicines;
- dental expenses, including orthodontic and prosthetic expenses;
- vision expense, including eye exams, glasses, contacts, and seeing eye dogs;
- hearing expenses, including hearing aids and exams;
- orthopedic expenses;
- counseling for learning disabilities, psychiatric care, and other counseling expenses;
- acupuncture;
- transportation to and from medical treatment;
- expenses for smoking cessation programs and prescription drugs to alleviate nicotine withdrawal.

In a **Limited Purpose Account**, qualified medical expenses include only the dental and vision expenses identified above, if not otherwise paid by any other plan.

Effective January 1, 2011, over-the-counter medications or drugs (except insulin) will not be qualified medical care expenses without a prescription.

Qualified expenses will not include charges for cosmetic surgery or other similar procedures. However, surgeries or procedures that are necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury arising from an accident or trauma, or a disfiguring disease will be included.

NOTE: Generally, you will not be taxed on your Medical Expense Reimbursement Account, up to the limits described in the Plan Administration Information Supplement at the end of the Summary. However, your Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your medical care expenses must be for you, your spouse or your Dependent(s), as defined in the Internal Revenue Code. If you are reimbursed for a claim that is later determined to not be for medical expenses of a Dependent because the individual did not meet the definition of Dependent, then you will be required to repay the amount to the Plan. Ultimately, it is your responsibility to determine whether a reimbursement under the Medical Expense Reimbursement Account is a qualified expense eligible for exclusion from federal income tax.

Dependent Care Expense Reimbursement Account

The Dependent Care Expense Reimbursement Account enables you to pay for out-of-pocket, work-related dependent daycare costs with your pre-tax Flexible Dollars. If you are married, you can use the account if you and your spouse both work, or in some situations, if your spouse is disabled or goes to school full-time. Single Employees can also use the account.

If you elect a Dependent Care Expense Reimbursement Account, you will be reimbursed for qualified employment related expenses that may be incurred for the care of the individuals listed below:

* Your qualifying children under age 13;

* Your disabled spouse or disabled qualifying child who lives with you for more than half the year;

* A disabled qualifying relative who lives with you for more than half the year and for whom you provide support for over one-half of the year (as defined in Code Section 152(d)without regard to subsection (d)(1)(B)); and

* A qualifying child with respect to the custodial parent (see Code Section 21(e)(5)).

Qualified expenses include charges you incur for daycare (child or adult), including certain expenses for nursery schools that are not primarily educational in nature or purpose. It does not include travel, clothing, entertainment, food and educational expenses.

Expenses that would otherwise qualify will not be eligible for reimbursement if:

* they would be paid to an individual that you or your spouse could take as a dependent exemption on your federal income tax return; or

* the provider of services is your child (including your stepchild, eligible foster child, adopted child and child lawfully placed for adoption) under age 19 as of the end of the taxable year; or

* they exceed your earned income (or your spouse's, if lower). For this purpose your earned income does not include amounts contributed to this option.

NOTE: Tax law imposes a dollar-for-dollar reduction of the expenses eligible for the dependent care tax credit if any expenses are funded through a Dependent Care Expense Reimbursement Account. This means that if the amount you place in a Dependent Care Expense Reimbursement Account exceeds your tax credit maximum ($3,000 for one child and $6,000 for two or more), you may not use the tax credit.

For example, if your yearly dependent care costs for one child are $6,000 and you fund $5,000 of this through a Dependent Care Expense Reimbursement Account, you cannot apply the remaining $1,000 toward the tax credit. This is because the $5,000 in your Dependent Care Expense Reimbursement Account exceeds the expenses eligible for the

tax credit maximum of $3,000 for one child. However, if your yearly dependent care costs for two children add up to $6,000 and you fund $5,000 of this through a Dependent Care Expense Reimbursement Account, you can apply the remaining $1,000 toward the tax credit.

It is important for you to determine whether you will pay less tax by reducing your compensation and receiving reimbursement for dependent care expenses through a Dependent Care Expense Reimbursement Account or by using your dependent care expenses to support the tax credit available for such expenses. You should seek the advice of a qualified tax advisor to help with this determination.

With your annual federal income tax return you will be required to file a statement which summarizes the payments you made for qualifying dependent care expenses in each tax year. Taxpayers filing Form 1040 will use Form 2441 for this purpose, those filing Form 1040A will use Schedule 2.

3) HOW TO FILE FOR REIMBURSEMENT FROM REIMBURSEMENT ACCOUNTS

Reimbursement Forms

When you incur a qualifying expense, you will need to submit a claim using a Request for Reimbursement form along with appropriate documentation of the expense. A Request for Reimbursement form can be obtained from your Employer.

Reimbursement

Claims for reimbursement of expenses incurred during a Plan Year or during the Grace Period may be submitted at any time during the Plan Year, or during the claims runout period following the end of the Plan Year (see the Plan Administration Information Supplement at the end of this Summary). Claims shall be paid to the extent of available Flexible Dollars allocated to the appropriate benefit and shall only be paid out of Flexible Dollars for the Plan Year in which the qualifying expenses were incurred (subject to the Grace Period described below). For purposes of the Plan, an expense is incurred when you or a covered Dependent receive services which give rise to a reimbursable expense and not when you are formally billed, or charged for or pay for the services. However, prepaid orthodontia services will be considered to be incurred when the fees are paid, as directed by your Employer.

If you do not have enough credits at the time a reimbursement request is filed, you will be reimbursed as follows:

* With respect to your Medical Expense Reimbursement Account: you will be reimbursed for the expense, up to the maximum amount that you have allocated to the Plan for the entire Plan Year, even if you have not yet made all your annual contributions.

* With respect to your Dependent Care Expense Reimbursement Account: you will be reimbursed for the expense, up to the amount that you have already contributed to the Plan, to the extent those year-to-date contributions exceed any amounts previously paid to you.

Unless you have made all payments required for coverage during the entire Plan Year, Flexible Dollars allocated to your Medical Expense Reimbursement Account shall cease to be available to pay claims for expenses incurred after the date required payments cease if you, for any reason (including termination from service) cease to make the required payments with respect to the benefit. Expenses incurred prior to the time you become a Participant for purposes of receiving Flexible Dollars and after the Plan Year in which you cease to be a Participant shall not be covered by this Plan.

If you switch from a General Purpose Medical Expense Reimbursement Account to a Limited Purpose Reimbursement Account during the year, an expense incurred after the date the account type is changed will be considered a reimbursable expense only if the expense is a qualified expense under a Limited Purpose Account (as described above). Keep in mind that you may not switch from a General Purpose Account to a Limited Purpose Account at any time other than effective with the first day of the month following the end of the Grace Period.

Payment of covered claims will be made directly to you. The administrator will, subject to the terms of the Plan, pay claims each month during the Plan Year to the extent that Flexible Dollars are available. After all Flexible Dollars have been exhausted, claims remaining unpaid at the Plan Year end will be canceled. In no event can these claims be resubmitted the next Plan Year, nor are any unpaid claims a liability of the Employer.

You will be notified in writing of any claims denied, in whole or in part, or if any additional information is required as provided below under the heading "Claims and Appeal Procedures."

Unused Credits

Any unused credits left in your reimbursement accounts in the Plan at the end of the Plan Year will be forfeited. Qualifying expenses that you incur late in the Plan Year, may be reimbursed within the Runout Period as described in the Plan Administration Information Supplement at the end of this Summary and will be paid first before any amount is forfeited. Because it is possible that you might forfeit amounts in your reimbursement accounts if you do not fully use the contributions that have been made, it is important that you decide how much to place in the reimbursement accounts carefully and conservatively. Remember, you must decide how much to place in the Medical Expense Reimbursement Account and Dependent Care Expense Reimbursement Account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in the Medical Expense Reimbursement Account and Dependent Care Expense Reimbursement Account will be used up entirely.

Unused Credits and Grace Period

Generally, if you have unused credits in any reimbursement account in the Plan at the end of the Plan Year, those unused credits are forfeited. However, as permitted by the IRS, your Employer has provided for a Grace Period following the end of each Plan Year so that qualified expenses

incurred during the Grace Period can be reimbursed from unused credits from the immediately preceding Plan Year.

The accounts to which the Grace Period applies and the length of the Grace Period are described in the Plan Administration Information Supplement at the end of this Summary.

Any expenses incurred during the Grace Period will first be paid from unused credits from the prior year in the applicable account. If the unused credits from the prior year are completely used during the Grace Period, additional expenses incurred during the Grace Period will then be paid from credits in the applicable account for the new year. Any credits from the prior year that are not used during the Grace Period will be forfeited.

You must be a Participant in the Plan as of the last day of the Plan Year in order to be reimbursed from unused credits for that Plan Year that are incurred during the Grace Period following the end of the Plan Year.

Since expenses incurred during the Grace Period will first be paid from any unused credits from the prior year, it is important to take this into account when electing salary deferrals into the account for the new year.

These rules are illustrated by the following examples published by the IRS. These examples are for a calendar year plan with a Grace Period of 2 ½ months. If your plan year does not end December 31 or the Grace Period set forth above is less than 2 ½ months, you need to adjust the dates in the examples below accordingly.

Example (1). Employer with a cafeteria plan year ending on December 31, 2005, amended the plan document before the end of the plan year to permit a grace period which allows all participants to apply unused benefits or contributions remaining at the end of the plan year to qualified benefits incurred during the grace period immediately following that plan year. The grace period adopted by the employer ends on the fifteenth day of the third calendar month after the end of the plan year (March 15, 2006 for the plan year ending December 31, 2005). Employee X timely elected salary reduction of $1,000 for a health FSA for the plan year ending December 31, 2005. As of December 31, 2005, X has $200 remaining unused in his health FSA. X timely elected salary reduction for a health FSA of $1,500 for the plan year ending December 31, 2006. During the grace period from January 1 through March 15, 2006, X incurs $300 of unreimbursed medical expenses (as defined in § 213(d)). The unused $200 from the plan year ending December 31, 2005 is applied to pay or reimburse $200 of X's $300 of medical expenses incurred during the grace period. Therefore, as of March 16, 2006, X has no unused benefits or contributions remaining for the plan year ending December 31, 2005. The remaining $100 of medical expenses incurred between January 1 and March 15, 2006 is paid or reimbursed from X's health FSA for the plan year ending December 31, 2006. As of March 16, 2006, X has $1,400 remaining in the health FSA for the plan year ending December 31, 2006.

Example (2). Same facts as Example (1), except that X incurs $150 of § 213(d) medical expenses during the grace period (January 1 through March 15, 2006). As of March 16, 2006, X has $50 of unused benefits or contributions remaining for the plan year ending December 31, 2005. The unused $50 cannot be cashed-out, converted to any other taxable or nontaxable benefit, or used in any other plan year (including the plan year ending

December 31, 2006). The unused $50 is subject to the "use-it-or-lose-it" rule and is "forfeited." As of March 16, 2006, X has the entire $1,500 elected in the health FSA for the plan year ending December 31, 2006.

Reimbursement After Termination of Employment

If you have elected noncash benefits under the Reimbursement Account options and your employment terminates or you otherwise become ineligible to participate in the Plan, you have the following options:

Terminate participation in the Plan. Such election will result in:

* no further contributions required to the Plan; and

* no further benefits under the Plan (except for medical expenses incurred prior to termination and dependent care expenses incurred at any time during the Plan year); or

Continue participation in the Plan under COBRA (See page 13) until the end of the current Plan Year. Such election will result in:

* additional contributions required (on an after-tax basis); and

* availability of additional benefits under the Plan for any expenses incurred throughout the Plan Year.

You may make your election in the manner specified by your Employer.

If you should die during any Plan Year and have not received the total reimbursements available for the Plan Year, your surviving spouse or Dependents can continue to submit claims for expenses incurred during that Plan Year on the same basis as described above if you should cease termination of participation in the Plan.

Distributions for Reservists

If you are a Reservist and are ordered or called to active duty in the military, you may receive all or a portion of your Medical Expense Reimbursement Account balance under the following circumstances:

(a) you are ordered or called to active duty for a period of at least 180 days or for an indefinite period; and

(b) The distribution from your Medical Expense Reimbursement Account is made during the period beginning with such order or call to active duty and ending on the last date reimbursement of expenses could otherwise be made for the Plan Year that includes the date of your order or call to active duty.

You are a Reservist for this purpose, if you are a member of the Army National Guard of the United States of America, the Army Reserve, the Navy Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

You may make a distribution request in the manner specified by your Employer.

4) CLAIMS AND APPEAL PROCEDURES

Pre-Tax Premium Payment Options

With respect to the denial of any claim for benefits from an insurance company or third-party benefit provider, paid for as a premium-type benefit under the Plan, the claims and appeal procedures of the insurance company or other third-party benefit provider shall apply.

Medical Expense Reimbursement Account

If a claim relating to your Medical Expense Reimbursement Account is denied, in whole or in part, the Plan Administrator will notify you of its decision in writing within 30 days after your claim is received by the Flexible Benefits Office. This period may be extended one time for up to 15 days, provided that the Plan Administrator 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 period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If an extension is necessary to obtain additional information from you, the notice will describe the specific information needed, and you will have 45 days from receipt of the notice to provide the information. Without complete information, your claim will be denied. The notice shall contain the following information:

(a) Specific reasons for the denial;

(b) Specific reference to pertinent Plan provisions;

(c) A description of any additional material or information necessary for you to validate such claim and an explanation of why such material or information is necessary;

(d) Information as to the steps to be taken if you wish to submit a request for review and the applicable time limits, including a statement of your right to bring a civil action under ERISA Section 502(a) with respect to any adverse benefit determination after appeal of your claim; and

(e) A copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or, in lieu thereof, a statement that such information is available free of charge upon request.

If a claim is denied, in whole or in part, because it exceeds the maximum amount that you have allocated to your Medical Expense Reimbursement Account for the entire Plan Year, the initial denial notice containing the explanation for denial shall serve as the notice of denial for all subsequent claims submitted during the Plan Year unless your annual election changes in

accordance with the rules under the heading "Changes in Plan Election." Any claim(s) submitted after the initial denial notice which exceeds your annual election will be considered denied as of the date submitted. You may contact the Flexible Benefits Office to request a year to date summary of claims paid from your Medical Expense Reimbursement Account.

If a claim is denied in whole or in part, you have a right to a full and fair review. Within 180 days after the date on which you receive a written notice of a denial (or, if applicable, within 180 days after the date on which such denial is considered to have occurred), you (or your Authorized Representative) may file a written request with the Plan Administrator for a review of your denied claim. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. You may submit to the Plan Administrator, written comments, documents, or other information in support of your request for review. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination. The review will be conducted by someone different from the original decision makers and without deference to the original decision.

The Plan Administrator will notify you of its decision in writing within 60 days after your request for review is received by the Plan Administrator. Such notification will contain specific reasons for the decision as well as specific references to pertinent Plan provisions and a statement that you are entitled to receive, free of charge, all relevant records, including internal rules, guidelines, or protocols relied upon in making the decision.

Dependent Care Expense Reimbursement Account

If a claim relating to your Dependent Care Expense Reimbursement Account is denied, in whole or in part, the Plan Administrator will notify you of its decision in writing within 90 days after your claim is received by the Flexible Benefits Office (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension is provided to you within the initial 90-day period). If written notification is not provided within such period, the claim will be considered denied as of the last day of such period and you may request a review. The notification shall contain the following information:

(a) Specific reasons for the denial;

(b) Specific reference to pertinent Plan provisions;

(c) A description of any additional material or information necessary for you to validate such claim and an explanation of why such material or information is necessary; and

(d) Information as to the steps to be taken if you wish to submit a request for review.

Within 60 days after the date on which you receive written notice of a denied claim (or, if applicable, within 60 days after the date on which such denial is considered to have occurred), you (or your Authorized Representative) may:

(a) File a written request with the Plan Administrator for a review of your denied claim and of pertinent documents, and

(b) Submit written issues and comments to the Plan Administrator.

The Plan Administrator will notify you of its decision on review in writing. Such notification will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Plan Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Plan Administrator to hold a hearing, and if written notice of such extension is given to you within the initial 60-day period). If the decision on review is not made within such period, the request will be considered denied.

Authorized Representative

You may authorize another person (known as an "Authorized Representative") to represent you and with whom you want the Plan Administrator to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in the Authorized Representative Form. An authorized Representative Form may be obtained from the Flexible Benefits Office or by calling 1-800-624-2755. An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an Authorized Representative. You can revoke the Authorized Representative at any time, and you can authorize only one person as your representative at a time.

5) YOUR COBRA RIGHTS

In accordance with Federal Law P.L. 99-272, Title X (COBRA), your Employer may be required to offer to you and your covered Dependents the right to continue your existing coverage (or coverage that existed on the day FMLA leave commenced) in the Medical Expense Reimbursement Account for the balance of the Plan Year if it would otherwise terminate.

COBRA continuation rights may be beneficial to you if you have unused dollars when your participation terminates. By extending coverage with after-tax dollars you may be able to use the unused dollars for claims incurred after coverage otherwise terminates. You will be provided with additional information if COBRA rights are available at time of termination of coverage.

6) YOUR RIGHTS UNDER ERISA

As a participant in the Medical Expense Reimbursement Account portion of the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Expense Reimbursement Account Plan participants shall be 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 and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and a copy 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 and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 Plan participants and beneficiaries. No one, including your employer, your union, 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part after you have exhausted the claims and appeals procedure under this Plan, 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 or a medical child support order, 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 should 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 your 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.

7) RIGHT TO TERMINATE/AMEND THE PLAN

The right is reserved for the Plan Administrator to terminate, suspend, withdraw or modify the Plan or the benefits under the Plan in whole or in part at any time. Any failure of insurance benefits for which premiums may be paid in whole or in part under this Plan, whether due to the Employer's negligence, gross neglect, or otherwise, including but not limited to failure to enroll a participant or pay premiums, shall not result in any liability by the Employer to a participant.

8) PRE-TAX PREMIUM PAYMENT BENEFIT OPTIONS AND INFORMATION

This Summary Plan Description does not describe the Pre-tax Premium Payment group medical plans(s) or other welfare plans for which the option is available to pay pre-tax under this Plan. Consult the Plan documents and Summary Plan Description for these benefit Plans.

9) PLAN ADMINISTRATION INFORMATION SUPPLEMENT

Effective Date:	July 1, 2005
Effective Date of this Summary:	January 1, 2011
Plan Year:	January 1 to December 31
Benefit Option(s):	Pre-Tax Premium Payments (specific benefits listed below) Medical Reimbursement Account Dependent Care Reimbursement Account
Employer:	MEADE SCHOOL DISTRICT 46-1
Address:	1230 DOUGLAS ST STURGIS, SD 57785
Employer Identification Number:	46-0307398
Plan Administrator (Plan Sponsor):	MEADE SCHOOL DISTRICT 46-1 ATTN: EMPLOYEE BENEFITS OFFICE 1230 DOUGLAS ST STURGIS, SD 57785 Telephone Number: 605-347-2523
Agent for Legal Services	The Plan Administrator is designated as agent for all purposes of legal process.
Plan Fiduciary:	Meade School District 46-1
Plan #	501

Eligibility: All permanent Employees who are not Excluded Employees (defined below) are eligible to participate in the Plan. In order to participate, an eligible Employee must make a timely election (see page 2).

Excluded Employees: The following Employees are *not* eligible to participate in the Plan because of requirements of law and the terms of the Plan: sole proprietors, self-employed individuals, partners of a partnership, 2% shareholders of an S corporation, and individuals classified by the Employer as independent contractors. In addition, the following Employees are NOT eligible to participate in the Plan.

- Employees who regularly work less than 30 hours each week
- Temporary or seasonal Employees and Employees hired only for a specific period of time or to complete a specific project

Pre-Tax Premium Payment Benefit Options:

- Medical benefit plans
- Dental benefit plans
- Cancer benefit plans

Plan Year: A twelve-month period beginning January 1 and ending the following December 31.

Minimum and Maximum Contribution Amounts:

* Option 1 - Medical Expense Reimbursement Option. The maximum amount you may contribute to this option each Plan Year is $5,000.00. The minimum amount you may contribute each Plan Year is $0.00 (contributed evenly over each payroll period).

* Option 2 - Dependent Care Expense Reimbursement Option. The maximum amount you may contribute to this option each Plan Year is $5,000.00 ($2,500.00 if you are married and filing a separate income tax return). The minimum amount you may contribute each Plan Year is $0.00 (contributed evenly over each payroll period).

Grace Period for Claims Incurred: Unused credits in your Medical and Dependent Care Expense Reimbursement Accounts at the end of a Plan Year may be used for expenses incurred during the 2 ½ months following the end of the Plan Year, which is March 15, 2012.

Claims Runout Period: You will have 91 days following the end of the Plan Year, which is March 31, 2012, to submit Medical and Dependent Care Expense Reimbursement Account claims that were incurred within that Plan Year (and within the Grace Period during the following Plan Year). At the end of the Runout Period, any unclaimed balance in either reimbursement account will be forfeited.

Minimum Reimbursement Check Amount: $25.00 (not applicable at the end of the claims runout period).