



SELF INSURED SCHOOLS OF CALIFORNIA

**SISC FLEX PLAN SUMMARY
EFFECTIVE OCTOBER 1, 2002
As amended effective July 1, 2006**

**SISC Flex Plan
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THE SISC FLEX ADVANTAGE

The SISC Flex Plan allows active employees to set pre-tax dollars aside to pay for certain medical and dependent care expenses. With careful planning, the SISC Flex Plan can save you dollars you would otherwise pay as taxes.

YES, TAX SAVINGS

Money you put aside in the Flex Plan is actually taken out of your earnings before federal income and social security taxes are deducted. This reduces your taxable income while still allowing you to pay for eligible dependent care and medical expenses.

FLEX ACCOUNTS

The Flex Plan is divided into three Flex Accounts:

1. **The Premium Payment Account:** Employee-paid medical, dental and vision premiums can be made on a pre-tax basis through this account.
2. **The Dependent Care Account:** Payments for daycare, home care, or child-care bills for care of a dependent child under age 13, a disabled child of any age, a disabled spouse or a disabled dependent parent can be made on a pre-tax basis through this account.
3. **The Medical Spending Account:** Payments for coinsurance, deductibles and most medical, dental and vision expenses that are not covered by insurance can be made on a pre-tax basis through this account.

SEPARATE FUNDS

Flex account funds are maintained separately within the Flex Plan. The amount you contribute to one Account can only be used for that Account and not for another Account. For example, contributions made to the Medical Spending Account cannot be used to pay Dependent Care Account expenses.

HOW DOES THE FLEX PLAN WORK?

You may contribute part of your salary or paycheck on a pre-tax basis to fund the Medical Spending Account or the Dependent Care Spending Account. You are responsible for paying the provider of services. When you incur an eligible expense, you may file a claim with SISC Flex. When the claim is approved, a reimbursement will be made to you.

The objective is to reduce your taxable earnings, not your take-home pay. With careful planning, you could **increase** your take-home pay by saving money on taxes through the SISC Flex Plan.

HOW SUSAN SAVES WITH SISC FLEX

Following are some examples of how pre-tax dollars work. Let’s look at the example for Susan on the right hand side of the table below. Susan is a married employee who makes \$48,000 a year, pays family premiums for health coverage and puts \$75 a month in the Health Care Spending Account to pay for medical expenses that are not covered by the SISC Health Plan.

	Ann - The Single Parent		Joe & Sally - A Working Couple		Susan – A Family Person	
	Without SISC FLEX	With SISC FLEX	Without SISC FLEX	With SISC FLEX	Without SISC FLEX	With SISC FLEX
Total Monthly Pay Less Non-Taxable Benefits	\$1,600	\$1,600	\$3,500	\$3,500	\$4,000	\$4,000
Insurance Premiums	\$0	\$187	\$0	\$291	\$0	\$379
Medical/Dental Expenses	\$0	\$60	\$0	\$100	\$0	\$75
Childcare Expenses	\$0	\$175	\$0	\$350	\$0	\$0
Total Pay Subject to Tax	\$1,600	\$1,178	\$3,500	\$2,759	\$4,000	\$3,546
Less Deductions						
Federal & State Taxes*	\$192	\$115	\$487	\$324	\$667	\$568
Social Security Tax	\$122	\$90	\$268	\$211	\$306	\$271
After Tax Income	\$1,286	\$973	\$2,745	\$2,224	\$3,027	\$2,707
After Tax Expenses						
Insurance Premiums	\$187	\$0	\$291	\$0	\$379	\$0
Medical/Dental Expenses	\$60	\$0	\$100	\$0	\$75	\$0
Childcare Expenses**	\$175	\$0	\$350	\$0	\$0	\$0
Spendable Income	\$864	\$973	\$2,004	\$2,224	\$2,573	\$2,707
Annual Increase in Take-Home Pay		\$1,308		\$2,640		\$1,608

* Federal and State taxes reflect 2000 Federal Tax rates and typical state taxes.

** Does not include any available tax credit for child care expenses.

Susan increased her spendable income because she paid for SISC Health premiums and non-covered medical expenses with pre-tax dollars, saving her \$1,608 in taxes.

PREMIUM ONLY PAYMENT (POP) PLAN ENROLLMENT

If you elect the POP Plan, your portion of the insurance premium will be deducted from your pay on a pre-tax basis. Alternatively, you may elect to make premium payments with an after-tax payroll deduction.

HOW TO PARTICIPATE IN THE MEDICAL SPENDING AND/OR DEPENDENT CARE ACCOUNT

The SISC Flex Enrollment Form has blanks for your annual Spending Account Deduction, the number of times you will receive a paycheck each year, and the Deduction that will be made each pay period. Indicate the amount you want deducted from your pay in the appropriate blank on the enrollment form.

To participate in the Medical Spending or Dependent Care Account you must complete an annual enrollment form.

How much you should contribute to your Medical Spending Account and/or Dependent Care Account depends on what you estimate your expense will be for the year. You must plan carefully before you contribute any part of your salary into the Flex Accounts. Add up what you plan to spend on dependent care and on medical expenses during the plan year to estimate how much to put into the Flex Plan. Make sure you complete the form correctly because you cannot make corrections or changes once the form has been submitted.

MAXIMUM AND MINIMUM FLEX ACCOUNT CONTRIBUTIONS

The maximum amount that can be contributed each year to the Medical Spending Account is \$3,600 and \$5,000 for the Dependent Care Spending Account. There is a minimum contribution of \$10 per month.

ELIGIBLE EMPLOYEES

Any person who is employed by a Qualified Employer and enrolled in the SISC Medical Plan is eligible to participate in the Plan. Eligible employees must be participating in the medical benefits under the SISC Health Benefit Plan on the first day of the Plan Year to be a Participant in the Plan. Retirees are not eligible under this Plan.

Employees who become eligible during the Plan Year and are participants in the medical benefits under the SISC Health Benefit Plan shall be allowed to participate in the SISC Flex Plan on the first of the month following eligibility.

Notwithstanding the foregoing, an employee may become eligible in the Flex Plan on his or her date of hire by a Qualified Employer, or if later, the date his or her Qualified Employer enters into a participation agreement with SISC, even though the employee is not enrolled in a SISC Medical Plan or a Health Benefit Plan. The preceding sentence shall be effective (1) as of the effective date of a participation agreement with SISC for employees of a Qualified Employer joining SISC on or after July 1, 2006 and (2) as of January 1, 2007 for employees of all other Qualified Employers participating before July 1, 2006.

An employee that has previously received an improper reimbursement of Dependent Care or Medical Care expenses may not reenroll in the SISC Flex Plan until such improper

reimbursement has been completely repaid either by offset from subsequently submitted claims or otherwise. The preceding sentence shall be effective as of July 1, 2006.

QUALIFIED EMPLOYER

A “Qualified Employer” is a school district that employs Eligible Employees and has entered into a written participation agreement with SISC for the purpose of providing benefits under the SISC Flex Plan to Eligible Employees of the employer.

DEPENDENTS

For purposes of eligibility under a Premium Payment Account and/or a Medical Spending Account your eligible dependents include:

- Your legal **Spouse** not legally separated from you
- Your unmarried **Dependent Children**
(See below under the heading “Dependent Children” for more details.)
- Your **Domestic Partner**
(See below under the heading “Reimbursement of Medical Expenses of your Qualified Domestic Partner from your Medical Spending Account” for more details on the conditions that apply to a domestic partner.)

QUALIFYING INDIVIDUAL

For purposes of reimbursement for dependent care expenses, a dependent means a Qualifying Individual as described below under the heading “Eligible Dependent Care Expenses.”

DEPENDENT CHILDREN

A Dependent Child of a Participant is an unmarried child that is either a “qualifying child” or “qualifying relative” as those terms are defined in Internal Revenue Code § 152, but determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof. The term “child” means a natural child, stepchild, adopted child (including a child placed for adoption with the Participant), or a foster child placed with you by an authorized agency or by court order.

Special Rule for Divorce/Separation. For purposes of eligibility under a Premium Payment Account and/or a Medical Spending Account, a Dependent Child to whom Code § 152(e) applies (regarding a child of divorced or separated parents) may be treated as a dependent of either parent. Generally, Code § 152(e) applies if one or both parents have custody of the child for more than half the calendar year and where the parents together provide more than half of the child’s support for the calendar year.

A child named in a qualified medical child support order (QMCSO), including a National Medical Support Notice that qualifies as a QMCSO, is a Dependent Child for purposes of eligibility under a Premium Payment Account and/or a Medical Spending Account.

FORFEITURE RULE

IRS regulations require that any amounts that are contributed to a Flex Account and are not used for eligible expenses during the Plan Year must be forfeited each year. Estimate your

expenses carefully so you do not put more money into the Flex Plan than you'll spend during the Plan Year.

Remember: Any unused amounts will be forfeited.

TRACKING YOUR BALANCE

During the Plan Year you can check your Spending Account balances on your SISC Flex Reimbursement check stub, your Quarterly Statement, or on the SISC Flex Web Site at <http://sisc.kern.org/flex/>

CHANGES IN STATUS ARE REQUIRED FOR CHANGING ELECTIONS

SISC Flex Plan elections may only be modified if you have an allowable change in status.

An allowable change in status is defined as one of the following:

- Change in the Participant's legal marital status, including marriage or divorce, death, legal separation/annulment
- Termination or commencement of employment by employee or spouse.
- Change in dependent eligibility (attainment of age, student status, etc.) under the SISC Health Plan
- Death of spouse/dependent
- Birth/adoption/placement for adoption of a child
- Reduction/increase in hours of employment by employee or spouse that affects eligibility for benefits
- Commencement or return from an unpaid leave of absence by employee or spouse.
- A change affecting employment-related expenses for dependent care such as a dependent turning age 13 and no longer qualifying as a dependent under the Internal Revenue Code.
- A change in dependent care provider or rates.

CONSISTENCY REQUIREMENT

The IRS requires that a change in election must be on account of a Change in Status and be consistent with the change in status to be allowable.

An example of complying with the consistency requirement would be adding a dependent to your insurance when you have a new baby. An inconsistent change would be requesting to drop dependent insurance when you have a new baby. Because the change in election is inconsistent with the change in status, it would not be allowed under the Flex Plan.

Another example: A couple who currently have children in day care and have a Flex Plan contribution of \$250 per month have a new baby in the middle of the Plan Year. The couple could increase their Flex Plan Dependent Care contribution to provide day care for the new child. The change in the contribution (increased amount) is consistent with the change in status (increased number of dependents receiving day care).

To request a change in election you must submit the proper change request form, along with appropriate documentation of the change, to the SISC Flex Office. The change will be processed under the following conditions:

*A revocation or amendment of participation must be made within sixty (60) days after the change in status occurs and will be effective for the balance of the Plan Year in which the election is made. **There are no exceptions to the 60-day timeframe for making election changes.** The change in election will be effective the first (1st) day of the month following the month in which the election change form is received.*

HIPAA SPECIAL ENROLLMENT RIGHTS

Certain other events also allow you to change your annual election if the election corresponds with a special enrollment event under HIPAA. As required by HIPAA, a special enrollment right arises under the following circumstances:

- Acquisition of a new Spouse or Dependent Child as a result of marriage, birth, adoption, or placement for adoption; or
- Loss of eligibility under a group health plan by anyone who would otherwise be eligible under the SISC Flex Plan, if the coverage is terminated because of:
 - Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation, or
 - Loss of coverage through an HMO that does not provide benefits to individuals who do not reside, live or work in the service area, or
 - Termination of employer contributions toward that other coverage, or
 - If the other coverage was COBRA Continuation Coverage and the coverage was exhausted.

An election change on account of birth, adoption or placement for adoption will be effective retroactive to the date of birth, adoption or placement for adoption, **provided you request a change in your annual election within 30 days of the birth, adoption, or placement for adoption.** Election changes for other special enrollment events (e.g., marriage or loss of other health coverage) will be effective as soon as practicable once your request for such election change has been received, **provided your request is made within 60 days of the event.**

Retroactive coverage of a newly acquired Dependent Child on account of birth, adoption or placement for adoption applies to the Premium Payment and Medical Spending Account components of the SISC Flex Plan, but not to the Dependent Care Account component. The effective date of coverage of a new Spouse or Dependent Child under the Dependent Care Account will be prospective for the balance of the Plan Year beginning as soon as practicable after the date the new benefit election and salary reduction agreement forms are received.

Payroll changes will be effective with the first pay period following approval of your request to change your salary reduction amount even if the effective date of your Dependent Child's coverage is retroactive.

FMLA AND OTHER LEAVES OF ABSENCE

You must be an active employee to participate in the Flex Plan, unless you are on an FMLA or other approved leave of absence. You should talk to your local district office to determine how to fund your account during an unpaid leave of absence.

If you do not make the salary reduction on a pre-tax basis or by after-tax contributions, your participation will cease after a thirty (30) day grace period. If your participation ceases for this reason, you may still submit claims for **eligible** Dependent Care and Medical reimbursement expenses incurred before participation ended.

If you return from FMLA leave or a qualified military leave under the Uniformed Services Employment and Reemployment Rights Act and commence employment again, you may choose to participate and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid, or to amend the salary reduction election, as described above, or to elect **not** to participate for the remainder of the Plan Year.

For other leaves of absence, if no coverage during leave is elected and you return to active work during the same Plan Year, and the salary reduction election has not been amended, as described above, then the same election you had before the leave must be maintained upon return from the leave.

TAXES AND OTHER BENEFITS

Your federal, state, social security, and medicare taxes are lowered when you use pre-tax dollars to pay for non-covered medical expenses and dependent care expenses through the Flex Plan. Expenses reimbursed under the Flex Plan **cannot** also be claimed as a deduction or credit on your tax return. You should also understand that lowering your taxable income means that you are paying less in Social Security taxes and your benefits may be affected when you retire or become disabled. Other benefits that are based upon your taxable income may also be reduced if you reduce your taxable income. Please contact your tax advisor to determine how participation in the Flex Plan may affect your personal situation.

FILING A CLAIM FOR DEPENDENT CARE AND MEDICAL REIMBURSEMENT EXPENSES

To receive reimbursement for dependent care and medical expenses, you must receive eligible dependent care and medical services and file a claim with SISC Flex. Complete a Reimbursement Account Claim Form and send it along with an itemized bill or receipt to the SISC Flex Plan Office for processing. In addition to the claim form, Medical Spending Account claims require an Explanation of Benefits (EOB) from your insurance carrier(s). Or, if the medical expense is not covered by insurance, an invoice from the provider which gives the provider's name, address, telephone number, the amount of the expense, a description of the expense, the date the expense occurred and the name of the patient. SISC Flex cannot reimburse claims based on balance due statements. Reimbursement claim

forms may be obtained from your District's Benefits Administrator, the SISC Flex Administrator, or the SISC Flex website at <http://sisc.kern.org/flex/>

Approved claims will typically be paid within ten (10) working days. If a claim is received after the cut-off date, it will be paid in the following processing period. If the check issue date falls on a Saturday, Sunday, or Holiday, checks will be issued on the next working day. The claim form must be completely filled out and all required receipts attached or the claim will be returned to you for completion or correction without being processed. **Do not forget to sign and date the claim form.** The *enrollee's* signature must be original on the claim form.

Make a copy of the claim form and any attached documentation for your records before sending it to SISC FLEX for processing.

Reimbursements will be made based on the Plan Year during which the service was provided. The Plan Year is the 12-month period beginning January 1st and ending on December 31st each year. [Except in the case of the first plan year which is from October 1, 2002 to December 31, 2002.]

Expenses and account balances cannot be carried over to the next Plan Year for reimbursement. For Medical Care Expenses, the Date of Service is the date you actually see the doctor or purchase the prescription. For Dependent Care Expenses, Date of Service is determined by when day care services are provided to the dependent, not when you pay the bill.

Reimbursement cannot be processed if the service was provided during part of the Plan Year when the employee did not participate in the Flex Plan.

Example: An employee hired in March elects to participate in the Medical Spending Account. The employee may not be reimbursed for medical services provided in February prior to the date their Medical Spending Account was established.

For 90 days after the end of the Plan Year, you will be able to submit reimbursement requests for expenses that were incurred (services rendered) during the Plan Year. In other words, if you receive a bill for an eligible medical service or dependent care service (incurred during the Plan Year) after the Plan Year ends; you can be reimbursed out of the Flex Plan if the claim is filed during this 90-day period.

Flex Plan Grace Period; Special Rules for Claims Incurred During a Grace Period

Beginning with the 2005 Plan Year, if there is an unused balance remaining in your Medical Spending Account at the end of the Plan Year, you will have a grace period of 2½ months after the end of the Plan Year (until March 15th) to incur claims that may be reimbursed from any funds remaining from the previous plan year. The grace period does not apply to the Dependent Care Account. .

The effect of the grace period is that you may have as long as 14 months and 15 days (the 12 months in the current plan year plus the grace period) to use the benefits or contributions to your Medical Spending Account for a plan year before those amounts are

"forfeited" under the "use-it-or-lose it" rule. If the two-and-a-half month extension period has passed and there is still money left in the account, the money will be subject to the "use-it-or-lose-it" rule, and the balance will be forfeited.

The new grace period should not be confused with the Plan's "run-out period." The run-out period still extends until March 31st of each plan year. This is a period for submitting documentation and eligible claims incurred anytime during the plan year, as well as claims incurred during the grace period mentioned above. Claims and supporting documentation must be received by the SISC office by March 31st in order to be considered filed during the run-out period.

Reimbursement from Dependent Care Account

In order to receive a reimbursement from the Dependent Care Account, you must have the funds available in your Dependent Care Account, in the amount you are requesting to be reimbursed. The Flex Plan cannot reimburse you for any amount over your Dependent Care Account balance at the time your claim is processed. Any amount claimed which exceeds the available funds in the Dependent Care Account, will be processed when the funds become available.

To be eligible for reimbursement for dependent care, you must be working or looking for work while your dependents receive care. You must furnish the IRS with the name, address and taxpayer identification number of the dependent care provider. This information must be reported on Form 2441 and filed with your personal annual tax return (Form 1040). If you are married, your spouse must be a wage earner, or a full-time student; or must be disabled and unable to provide for his own care. You cannot claim more than your salary or your spouse's annual salary, whichever is less, in dependent care expenses. If your spouse is disabled or a full-time student, the IRS Regulations assume that he/she earns \$200 per month (one dependent) or \$400 per month (two dependents).

Reimbursement of Expenses following Termination

If you terminate employment, you may elect to continue participation in the Medical Spending Account of the Flex Plan and pay the required contributions, after your termination of employment, under COBRA. Medical expenses are reimbursable if they are incurred during COBRA coverage. As discussed above, reimbursable medical expenses from the Flex Plan also include expenses incurred during the 2½ month grace period that follows the end of the year if you have an unused balance left over in your Medical Spending Account.

MEDICAL EXPENSES ELIGIBLE FOR REIMBURSEMENT

Medical care expenses include amounts paid for the diagnosis, cure, treatment, or prevention of disease, and for treatments affecting any part of or function of the body. The expenses must be to alleviate or prevent a physical defect or illness and must be considered a deductible medical expense pursuant to IRS regulations.

According to IRS guidelines, the following deductible medical expenses are eligible for reimbursement under a Flex Plan as long as they are not eligible for reimbursement from any other source:

- Adoption - Medical Expense (incurred before adoption is finalized)
- Alcoholism Treatment
- Ambulance
- Artificial Limbs
- Artificial Teeth
- Braille Books/Magazine (difference between regular material and Braille materials)
- Car Controls for Handicapped
- Chiropractic Services
- Christian Science Practitioners (payments for medical care)
- Coinsurance Amounts and Deductibles
- Contact Lenses and Solution
- Crutches
- Dental Treatment
- Diagnostic Tests
- Drug Addiction Treatment
- Eye Examinations and Eyeglasses
- Guide Dog or Other Animal (purchase, training, and care of animal)
- Hearing Aids and Examinations
- Hospital Services
- Injections
- Insulin
- Laboratory Fees
- Lasik Eye Surgery
- Learning Disabled Child:
- Special School/Teacher
- Medical Monitoring and Testing Devices (if prescribed by physician for a particular ailment).
- Medicines (If prescribed by physician to treat a specific ailment and if only available by prescription.)
- Occlusal Guards (to prevent teeth grinding)
- Operations (Legal operations which treat a specific ailment)
- Optometrist
- Organ Transplants
- Orthodontia (unless for cosmetic purposes)
- Osteopath
- Over-the-Counter drugs and medicines (if they are primarily for medical care, and not for personal, general health or cosmetic purposes)
- Oxygen
- Peridental Fees
- Physical Exams (except for employment-related physicals)
- Physical Therapy (for specified medical purpose)
- Prescription Sunglasses
- Private Hospital Room
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Radial Keratotomy
- Surgery
- Telephone for the Deaf
- Transportation for Seminar on Medical Condition
- Cost of Seminar on Medical Condition
- Vaccinations
- X-Rays

This list is non-inclusive and does not represent all allowable or non-allowable charges. You may refer any further questions regarding allowable and non-allowable charges to SISC.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one's general health (for example, vacations) are not expenses for medical care.

- Body Piercing
- Breast Pump
- Chauffeur Services
- Controlled Substances
- Cosmetic Products, Services or Surgery
- Dancing or Swimming Lessons, even if recommended by a physician
- Diapers for Infants or Diaper Service
- Electrolysis
- Expenses that are not substantiated
- Fees written off by provider
- Food Supplements
- Funeral Expenses
- Hair Transplant
- Health Club Dues
- Herbs
- Hot Tubs or Air Conditioners
- Household and Domestic Help
- Illegal Operations and Treatments
- Insurance Premiums
- Liposuction
- Long-Term Care Services
- Massage Therapy
- Maternity Clothes
- Medical Maintenance Programs
- Medical Savings Accounts (MSA)
- Personal Hygiene Products
- Personal Items
- Preferred Provider Discounts
- Pregnancy Kits
- Salary expense of a nurse to care for a healthy newborn at home
- Swimming Lessons
- Tattoos or Tattoo Removal
- Transportation expenses to and from work
- Trip or vacation taken for well being
- Uniforms
- Vitamins without a prescription

This list is non-inclusive and does not represent all allowable or non-allowable charges. You may refer any further questions regarding allowable and non-allowable charges to SISC.

CAUTION: The IRS makes changes in the definition of deductible medical expenses each year. Be sure to consult your accountant or tax attorney with questions about eligible medical expenses *prior to enrolling*.

Reimbursement of Medical Expenses of your Tax-Qualified Domestic Partner from your Medical Spending Account

Your Tax-Qualified Domestic Partner's eligible medical expenses may be reimbursed from your Medical Spending Account if:

- (1) the domestic partnership is registered with the State of California in accordance with Family Code section 297 (i.e., a "Registered Domestic Partnership"), and
- (2) the domestic partner is your "qualifying relative" as defined in section 152(d) of the Internal Revenue Code (determined without regard to section 152(d)(1)(B) thereof).

It is important that each of these requirements be met otherwise you will be unable to claim expenses for your domestic partner under the Medical Spending Account. Before the SISC Flex Plan will reimburse you for your Tax-Qualified Domestic Partner's eligible medical expenses, you will need to submit an affidavit that your domestic partner satisfies the above conditions. You must also submit a copy of your Certificate of Domestic Partnership from the State of California. You may apply for a Certificate of Domestic Partnership by filing a Declaration of Domestic Partnership form with the California Secretary of State.

Domestic Partnership must be Registered with the State of California

A Domestic Partner is an individual in a domestic partnership with an employee. The Employee and the Domestic Partner must have established a domestic partnership in the State of California in accordance with Family Code section 297 (i.e., a "Registered Domestic Partnership"). Under California law, a Registered Domestic Partnership is established when:

- Both persons file a declaration of domestic partnership with the Secretary of State.
- Both persons have a common residence.
- Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or annulled.
- The two persons are not related by blood in a way that would prevent them from being married to each other in California.
- Both persons are at least 18 years of age.
- Either of the following is true:
 - Both persons are of the same sex, or
 - The domestic partner is of the opposite sex and one or both persons are over age 62 and also meet the eligibility criteria for Medicare benefits.

- Both persons are capable of consenting to the domestic partnership.

A Domestic Partner must be Tax Qualified

Your same-sex or opposite-sex domestic partner must qualify as your tax dependent under Internal Revenue Code (Code) § 152 (determined without regard to section 152(d)(1)(B) thereof) for coverage under your Medical Spending Account and will qualify only if the following conditions are met:

- You and your domestic partner have the same principal place of abode for the entire calendar year;
- Your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law);
- During the calendar year you provide more than half of your domestic partner's total support;
- Your domestic partner is not your (or anyone else's) "qualifying child" under Code § 152(c); and
- Your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S.

Please consult you tax advisor if you have any questions about whether your domestic partner qualifies as your tax dependent or if you have questions about the tax consequences of providing coverage through the Medical Spending Account to your domestic partner.

Your Responsibility to Notify SISC

You must notify SISC immediately if your domestic partnership is terminated for any reason. Also notify SISC right away if your domestic partner no longer shares your same principal place of abode or no longer is a member of your household for the entire calendar year.

Paying Health Insurance Premiums for your Tax-Qualified Domestic Partner through the Premium Payment Option

You may pay health insurance premiums to provide medical benefits for your Tax-Qualified Domestic Partner through the Premium Payment option. These premiums may be paid on a pre-tax basis only if your Tax-Qualified Domestic Partner is a tax-qualified dependent by satisfying the conditions of a "qualifying relative" in section 152(d) of the Internal Revenue Code (determined without regard to section 152(d)(1)(B) thereof). See the conditions described above in the section "Your Domestic Partner must be Tax Qualified."

ELIGIBLE DEPENDENT CARE EXPENSES

"*Dependent Care Expenses*" means employment-related expenses incurred on behalf of any Dependent who meets the requirements to be a *Qualifying Individual*, as defined below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

1. Each Dependent for whom you incur the expenses must be a Qualifying Individual – that is, he or she must be:
 - A person under age 13 who is your “qualifying child” under Internal Revenue Code § 152(c) (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild, foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year); or
 - any person (other than your spouse) who (i) is physically or mentally incapable of caring for himself or herself, and (ii) has the same principal place of abode as you for more than one-half the year, and (iii) meets the applicable requirements for a dependent under Internal Revenue Code § 152; or
 - your spouse if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the Plan Year.

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual only with respect to the custodial parent even when the noncustodial parent is entitled to claim the dependency exemption for the child.

2. No daycare reimbursement will be made if the reimbursement would exceed the balance in your Dependent Care Account. In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the Plan Year, would exceed the applicable statutory limit. Your applicable statutory limit is the smallest of the following amounts:
 - your earned income for the calendar year (after your Salary Reductions under the Plan);
 - either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status.
3. The expenses are incurred for services rendered after the date of your election to contribute to the Dependent Care Account and during the current Flex Plan Year.
4. The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.
5. You (or you and your Spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a Qualifying Individual.
6. The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.

7. If the expenses are incurred for services outside your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.
8. If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
9. The person who provided care was not your Spouse, a parent of your under age 13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
10. The expenses are not paid for services outside your household at a camp where the Qualifying Individual stays overnight.

The Flex Plan is subject to IRS nondiscrimination regulations. Each year the Dependent Care and Medical Spending Accounts are tested to insure they do not discriminate in favor of highly compensated employees. If Dependent Care Accounts are determined to be discriminatory, contributions to highly compensated employees will be returned and amounts treated as taxable income.

For more information about what items are – and are not – deductible Dependent Care Expenses, consult IRS Publication 503 (Child and Dependent Care Expenses), under the heading “Tests to Claim the Credit.” Use the Publication with caution, because it was meant only to help taxpayers figure out whether they can claim the Dependent Care Credit, not to explain what is reimbursable under a Flex Plan. Some of the statements in the Publication aren’t correct when determining whether that same expense is reimbursable from your Flex Plan. For example, regardless of what the Publication says, you must incur the expense during the Plan Year to get reimbursed for it under the Flex Plan. Be sure to ask the Administrator for help if you have any doubts about which expenses are – and are not – reimbursable.

DEPENDENT CARE TAX CREDIT AND THE FLEX PLAN

You may not claim any other tax benefit for the tax-free amounts you receive under the Flex Plan, although the *balance* of your Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Internal Revenue Code § 21 (*Dependent Care Tax Credit*) (e.g., if you elect \$3,000 of coverage under the DCAP and are reimbursed \$3,000, but you had Dependent Care Expenses totaling \$5,000, you could count the excess \$2,000 when calculating the Dependent Care Credit). Note: the amount of any Dependent Care Credit you may have available will be offset by any DCAP Benefits received under the Plan.

Flexible Spending Account Worksheet

This worksheet is designed to help you estimate what your dependent care and unreimbursed medical expenses will be for the coming year. It will help you decide how much you need to set aside in your Dependent Care and Health Care Spending Accounts in the Flex Plan. Remember, unreimbursed refers only to expenses you paid out-of-pocket. **DO NOT** include costs for services that will be covered by your health insurance.

Dependent Care Account:

(Cost of dependent care for children under 13 years.)

$$\begin{array}{rcccl}
 \$ & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} \\
 \text{Monthly Expense} & & & \text{\# of Months} & & \text{Total Annual Cost/Expense}
 \end{array}$$

<u>Medical Spending Account</u> (Estimate your <i>uninsured</i> medical costs or co-pays per year)	Projected Expenses
Insurance Deductibles	\$
Insurance Co-payments	\$
Dental Deductibles	\$
Dental Expenses	\$
Vision Deductibles	\$
Vision Expenses (Eyeglasses, contacts, solution, etc.)	\$
Hearing Expenses	\$
Prescriptions	\$
Medically Required Equipment	\$
Chiropractic	\$
Orthodontic	\$
Counseling Services	\$
Other Medical Expenses (Lab fees, x-rays, tests, etc.)	\$
Total Annual Cost/Expense	\$

CONTINUATION COVERAGE

“Continuation Coverage” means your right, or your Spouse’s and Dependents’ right, to continue the same coverage under any component medical benefit plan (here, the medical coverage under the SISC Health Plan and the Medical Spending Account) that was in place the day before a *Qualifying Event* if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation coverage under federal law is provided under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Your Employer is subject to COBRA.

A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your Spouse;
- your becoming entitled to receive Medicare benefits; or
- your dependent’s ceasing to be a dependent.

For a Qualifying Event other than a change in your employment status or death, it would be your obligation to inform the Administrator of the qualifying event within 60 days of its occurrence. The Administrator, in turn, will furnish you (and your Spouse, as the case may be) with separate, written options to continue the coverages provided at stated premium costs with respect to each health plan in which you are participating. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

Certain Participants with Medical Spending Accounts will be eligible for COBRA Continuation Coverage if they have positive Medical Spending Account balances at the time of a Qualifying Event (taking into account all claims submitted before the date of the qualifying event). This allows you to continue coverage and incur eligible medical expenses for reimbursement under the Flex Plan. You will be notified if you are eligible for COBRA Continuation Coverage. However, even if COBRA is offered for the year in which the Qualifying Event occurs, COBRA coverage for the Medical Spending Account will cease at the end of the year and cannot be continued for the next Plan Year.

GENERAL FLEX PLAN INFORMATION

The SISC Flex Plan is sponsored by the Self Insured Schools of California and is intended to qualify as a cafeteria plan under Internal Revenue Code Section 125.

The SISC Flex Plan is not governed by the Employee Retirement Income Security Act (ERISA).

PARTICIPATING EMPLOYERS

Numerous school districts participate in the SISC Health Plan and Flex Plan. SISC is the sponsor of the Plan and has the responsibility for administration of the Plan. SISC also retains the authority to amend the Flex Plan at any time and any amendments apply to the employers and employees who participate in the Flex Plan.

CONTACTING THE SISC FLEX PLAN

SISC FLEX

P.O. Box 1808

Bakersfield, CA 933033-1808

Contact: SISC Flex Administrator

Phone: (661) 636-4411

800#: 1-800-972-1727

Email address: SISCFLEX@kern.org

SERVICE OF LEGAL PROCESS

The name and address of the Plan's agent for service of legal process is:

SISC Flex Administrator

SISC Flex

1300 17th Street

Bakersfield, CA 93303-1847

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