Forsyth County Schools

Forsyth County Schools Section 125

Summary Plan Description

ShawHankins

Right Partner. Right Benefits.

Forsyth County Schools Section 125, also known as Cafeteria Plan

Summary Plan Description

This booklet contains a summary in English of your plan rights and benefits under the Forsyth County Schools Section 125. If you have difficulty understanding any part of this booklet, contact Forsyth County Schools, the Benefit Plan Administrator, at his/her office in 1120 Dahlonega Hwy, Cumming, GA 30040. Office hours are from 8 A.M. to 5 P.M. Monday through Friday. You may call the Plan Administrator's office at 770-887-2461 for assistance.

This Plan is established by the above named employer and is the only employer offering the benefits of the Plan.

Plan Purpose

Forsyth County Schools Section 125 (also known as Cafeteria Plan) is a benefit program that allows you to use benefit dollars in a cost effective manner which best suits your needs. Section 125 of the Internal Revenue Code permits Forsyth County Schools, the Employer, to offer you the opportunity to get involved in designing your personalized benefit plan on a tax-favored (pretax) basis.

Who Is Eligible To Enroll In The Plan

You are eligible for this Forsyth County Schools Section 125 if you meet the eligibility requirements set forth in this Flexible Benefit Plan. All Employees are eligible for this plan.

How And When To Enroll

After you become eligible, you must select which benefits you would like to purchase by salary reduction through the Plan. Your decision must be made during the enrollment period designated by your employer preceding the Plan Year for which it will be in effect. If you are a newly-hired employee, you must make your decision during the month immediately preceding your becoming eligible. Prior to each Plan Year the Employer will provide you with a written or online election notice that will enable you to identify the benefits in which you wish to participate and the portion of your compensation reduction that may be applied to provide each benefit.

If for some reason, as a newly eligible employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent possible. If you are already a Plan Participant and you fail to complete an election form for the upcoming Plan year, then you will maintain the benefit options that you elected for the prior year, but will not be eligible to participate in the available Reimbursement accounts.

You may design a completely new plan each Plan Year during the enrollment period designated by your Employer. Keep in mind that your choices are in effect for the entire Plan Year. *Only under special circumstances,* such as a change in status, changes in the cost of coverage under the plan, and certain other events, may you apply to change your selected benefits. Generally, the change must be consistent with the change event; to the extent it is necessary or appropriate as a result of the change.

Special circumstances also include cost and coverage changes to a health plan, such as a significant increase in the cost of your coverage, a significant decrease in or cessation of your coverage or a significant change in your health coverage or your spouse's attributable to your spouse's employment. For these circumstances, however, only a change to another health plan with similar coverage is permitted. Think about your needs carefully because the benefits you choose but do not use cannot be converted to cash or accumulated from year to year.

Rules for change in benefits due to a Change in Status in accordance with the following:

A Participant may drop coverage if the cost of that coverage significantly increases and there is no similar alternative coverage available.

An Eligible Employee, who is not enrolled, or are enrolled in a similar benefit options may enroll in a coverage, when there has been a significant decrease in the cost of the desired coverage.

An Eligible Employee, who is not enrolled, or are enrolled in a similar benefit option, may enroll in a new coverage when a new benefit option is added or a benefit option is significantly improved.

When a significant coverage is no longer available resulting in a loss of coverage under this Plan, a Participant may change to another benefit option, if available, or cease enrollment.

Participants may make a change in benefit options that corresponds with changes made under a cafeteria plan of the spouse's or dependent's employer including changes made under a domestic partner's plan, or the plan of the employee's employer. The change request must be combined with adequate documentation describing the change in coverage for which the Participant, dependent, or domestic partner is covered.

Participants may make a change in coverage to add self or dependent who lost coverage under a health plan maintained or administered by a government or educational institution.

Whenever a Participant in this Plan is making a change in benefit options due to a Change in Status, the Participant may also make changes in life, disability, and dismemberment (including accidental death and dismemberment) coverage even though eligibility for such coverage is not affected by the Change of Status event.

If you should terminate your employment and stop your elections under this Plan, you may, if rehired, begin to participate in the Plan again after re-satisfying the eligibility requirements. However, you may not make a new election which is effective during the Plan Year in which your service with the Employer was terminated.

If, for any reason, you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pretax contributions until the next Plan Year.

FMLA Leave.

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take be effected in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

Schedule Of Flexible Benefits

Benefits may be purchased through the Flexible Benefits Plan with pretax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the various benefit plan Reimbursement accounts are provided by the Employer on the Enrollment Form, and as shown on the attached Schedules A, B, and C.

The benefits from which you may choose include:

Premium Conversion Plan

You may purchase the above coverage for yourself, (and in some cases for your qualified dependents), through the Flexible Benefits Plan. You may pay for these benefits using pretax dollars that are automatically deducted each designated pay period.

Premium Conversion Account

The purpose of this Plan is to allow employees to select among cash compensation and certain nontaxable benefits, namely coverage under one or more benefit programs maintained by your Employer. This Employer intends that the Plan quality as a cafeteria plan under Section 125 of the Code and that the benefits provided under the Plan will be eligible for exclusion from Federal Income Tax.

The Premium Conversion Plan is offered as a part of this Flexible Benefit Plan.

The Plan is a "Salary (or wage) Reduction" plan. This means that you pay your share of the cost of your benefits by electing to have your compensation reduced. You will decide on the amount of your salary reduction on an Enrollment and Salary Reduction Form available from your Plan Administrator. The amount of your agreed salary reduction will be placed in a Premium Conversion Account, maintained by your Employer from which payments for premiums for the various insured benefit plans maintained by your Employer in which you participate will be made. There is in your Premium Conversion Plan's Summary Plan Description a listing of the plans covered by this Premium Conversion Plan, along with the amount of the current premium from which you may make your selection.

The money you contribute to pay for your benefits is not subject to Federal income, Social Security or Unemployment taxation. Therefore, your benefit costs are quite low, and in some cases even result in a net increase in spendable income for you, after paying for your benefits.
Failure to participate in this Plan assumes you want your salary paid to you in cash.

How the Premium Conversion Account Plan Works

When you become eligible, you will be required to complete a Premium Conversion Plan Enrollment and Salary Reduction Form available from your Plan Administrator. The Form is an agreement between you and your Employer where you and your Employer list the benefits offered for the Plan Year. It will specify the amount you have agreed to contribute towards the cost of these benefits. Your salary reduction amounts will be credited to your Premium Conversion Plan Account, maintained by your Employer, and the funds in this account will be used to pay, on your behalf, the selected plan premiums.

Reimbursement accounts - Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible reimbursement accounts.

- Compensation redirection authorized for both medical (and employer provided dependent care contributions, if available,) reimbursement is in effect for the entire year unless you have a change in family status ---such as marriage, divorce, death of a child or spouse, adoption or birth of a child, termination or commencement of your spouses' employment, the switching from part-time to full-time employment status or the reverse by you or your spouse or taking of an unpaid leave of absence by you or your spouse.
- You must use all the funds in your reimbursement account by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Reimbursement account, it is wise to be conservative in your estimate of future reimbursable expenses.
- You will receive statements periodically to remind you how much is left in your account. This money must be used for expenses incurred before the end of the Plan Year or be forfeited. You may continue to submit claims up to three months after the Plan Year end for the prior year's expenses. Employees who terminate employment during the Plan Year will be given three months from their date of termination in which to submit request for reimbursement for expenses incurred before termination.

About Social Security Taxes

Social Security taxes are not deducted from the amount you pay in premiums on a pretax basis. This could result in a small reduction in the Social Security benefits you receive at retirement. This is because Social Security benefits are based on what you earn while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted each year, and is currently $90000. If your salary is above the TWB your Social Security benefit is not likely to be affected. If your salary were below the TWB, the benefit would be reduced. The tax advantages you gain through this Plan may offset any possible reduction in Social Security benefits.

About Your Retirement Benefits

Reducing your compensation to obtain Benefit Credits under this Plan may in no way affect the amount of any Employer sponsored retirement plan for which you are or may be entitled to except your Social Security benefits mentioned in the above paragraph.

Future Of The Flexible Benefit Plan

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you are entitled before the date of the amendment or termination.

Family And Medical Leave

As an employee of Forsyth County Schools, you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work-weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for Forsyth County Schools for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a new born child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent) or a personal health condition.

As a participant in the medical part of the Flexible Benefit Plan, you have while on leave under the FMLA the option to continue your health benefits on the same terms and conditions as immediately prior to taking your FMLA leave. You and your eligible dependents shall remain covered under this plan while you are on FMLA leave, as if you were still at work, Your coverage will be maintained until you return to work or, if earlier, you notify Forsyth County Schools that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before or at the end of the FMLA leave, you and your eligible dependents shall immediately become covered under the plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave. More details on your FMLA leave rights and benefits while on FMLA leave are available for your Plan Administrator.

The following options are available for FMLA payments:

Qualified Medical Child Support Orders

Generally your Plan benefits may not be assigned or alienated. However, an exception applies in the case of "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either:

(1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or
(2) enforces certain laws relating to medical child support. An "alternate recipient" is any child or a Participant who is recognized by a medical child support order as having a right to enrollment under the Participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if he or she received a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

Maternity And Newborn Coverage

Since this Plan may offer maternity and newborn coverage, you are advised that under Federal law, this Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length or stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods.

Administrative Facts

Plan Sponsor and Administrator

The Flexible Benefit Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. The Plan Administrator has appointed Forsyth County Schools to be responsible for the day-to-day operation of the Plan, whose address is 1120 Dahlonega Hwy, Cumming, GA 30040, whose telephone number is 770-887-2461.

The Employer has appointed Forsyth County Schools whose address is 1120 Dahlonega Hwy, Cumming GA 30040 and whose telephone number is (770)887-2412 as claims manager/administrator.

Plan Year

The First Plan Year will begin Tuesday, January 01, 2008 and ends Wednesday, December 31, 2008. The subsequent Plan Year will begin Thursday, January 01, 2009.

Name of Plan and Employer Plan Identification Numbers

The Employer Identification Number (EIN) assigned to Forsyth County Schools by the Internal Revenue Service (IRS) is 58-6000243. The Plan Number (PN) assigned to this Section 125 by the Employer is 501.

The Name of this Plan is Section 125, also known as Cafeteria Plan, established by the Employer, Forsyth County Schools, whose address is 1120 Dahlonega Hwy, Cumming GA 30040. For more information on the Plan Sponsor, see Administrative Facts section. The effective date of this Plan is Tuesday, January 01, 2008.

Service of Legal Process

Forsyth County Schools the Employer has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Employer by directing the process to the Plan Administrator indicated above.

Classification and Funding

The Plan is classified as a Code Section 125 cafeteria plan by the Internal Revenue Service. It includes a Health Flexible Reimbursement account, (herein called "Medical Reimbursement Account") classified by the Department of Labor as a "welfare plan", and includes a Dependent Care Flexible Reimbursement account (herein called "Dependent Care Reimbursement account). The Plan also includes a Premium Conversion Plan. The Plans are funded by employer and employee contributions.

Health Insurance Issuer

Currently, there is no health insurer involved in providing benefits to this Plan.

Third Party Administrator

Currently, no Third Party Administrator is associated with this Plan.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the Employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Statement Of ERISA Rights

"ERISA Rights" means your rights obtained by Federal Law:

Statement of ERISA Rights:

"As a participant in **(Q-1) Flexible Benefit Plan)** you are entitled to certain rights and protection under the Employees Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.
- Examine, without charge, at the plan administrator's office and other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- Obtain copies of all plan documents and other information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description (SPD) and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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. If your claim for a welfare benefit is denied in whole or in part, you must receive explanation of the reason for the denial. You have a right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials under 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 $100 a day until you receive the material unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that the 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 the claim is frivolous. If you have any question about your plan, you should contact the plan administrator. If you have any question about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Administration, (EBSA) U.S. Department of Labor, 200 Constitution Avenue NW Washington, DC 20210
You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 1-866-444-3272.

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Protected Health Information (PHI) provisions of the Health Insurance Portability and Accountability Act of 1997 (HIPAA) and its regulations ("Rules") include privacy protections impacting group handling health plan medical or financial information that could identify an individual. Individually identifiable information is protected whether it is in electronic, paper or oral format. The HIPAA rules give individuals control over health and financial information related to their health care. PHI may be used only for limited purposes without consent, and in many situations only upon individual authorization. Regarding their own PHI, you have the right to:

(1) object to using information;
(2) gain access to information;
(3) change information; and
(4) obtain an accounting of any information disclosures.

An underlying principle of the rules is that the "minimum necessary" disclosure should be the standard when using or disclosing information in the normal course of treatment, payment or health plan operations.

You are guaranteed access to your PHI and have the right to: (1) copy and amend health information; (2) receive an accounting of PHI uses; and (3) receive notices of health plans' information practices. You have the right to request that PHI use and disclosure be restricted even for treatment and payment purpose.

The Plan places restrictions on the Employer's use or disclosure of PHI received from the plan or an insurer. Insurers may determine what information will be available to the Plan.

The Plan will meet the minimum necessary uses and disclosures provisions of HIPAA for PHI. However, the minimum necessary provisions *do not apply* to the following:

- Disclosures to or request by a health care provider for treatment purposes;
- Disclosures to the individual who is the subject of the information;
- Uses or disclosures made based on an authorization requested by the individual;
- Uses or disclosures required for compliance with HIPAA's transaction standards (see 813);
- Disclosures to HHS when the rule requires the disclosure of information for enforcement purpose; and

- Uses or disclosures that are required by other laws.

Any uses or disclosures for which the covered entity has a valid authorization is exempt.

Marketing

The group health plan(s) and other covered entities, as defined by HIPAA, will not use or disclose PHI for marketing purposes without your authorization, except for face-to-face communications with the individual or promotional gifts of nominal value.

Communications that are part of treatment or are about a plan's benefits, services or operations are excluded from the definition of marketing, even if they promote the use or sale of a service or product.

Specifically excluded from the definition of marketing communications about:

- Participating providers and health plans in a network, the services offered by a provider or the benefits covered by a health plan;
- Treatment of the individual; and
- Case management or care coordination for the individual, or directions or recommendations for alternative treatments, therapies, health care providers or settings of care to that individual.

This health plan is not engaging in marketing when it advises enrollees about other available health coverage that could enhance or substitute for existing health coverage. For example, if a child is about to age out of coverage under a family policy, the plan may send the family information about continuation coverage for the child. This exception does not extend to excepted benefits under HIPAA, such as accident-only policies or auto medical liability, nor to other lines of insurance. For example, a multi-line insurer may not use PHI to promote its life insurance policies.

It is not marketing for a health plan to communicate about health-related products and services available only to plan enrollees or members that add value to but are not part of a plan of benefits. To qualify for this exclusion, the communication must meet two conditions:

(1) It must be health-related. For example, offers of discounts for eyeglasses may be considered part of plan benefits. This exclusion appears to included wellness programs that offer incentives to adopt healthy lifestyle behaviors.

(2) It must offer an added value of plan membership and not merely be a pass-through of a discount or item available to the public at large. Thus, a plan could offer its members a special discount for a health/fitness club, but not pass along to its members discounts that the members could obtain directly from the club.

For marketing activities permitted by an authorization, if there is remuneration, the marketing material must state that the entity making the communication is being paid by another entity.

Underwriting

An insurer that receives protected group health plan information for underwriting, premium rating and other similar purpose – and that coverage is not placed with the insurer- cannot use or disclose the information for any purpose other than as required by law.

Verification

In any disclosure other than those allowing the individual to agree or object, verifying the identity of anyone requesting PHI who is not known to the health plan or other covered entity must first occur.

If disclosure is conditional on documentation or statements from the person seeking PHI, that documentation or statement must be obtained before the PHI can be disclosed.

Legal Control

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

This is a Summary Plan Description only. This Plan is part of another Plan, The Flexible Benefit Plan, so your specific rights to benefits under the Plan are governed solely, and in every respect, by Forsyth County Schools Flexible Benefits Plan Document, and this Flexible Benefit Plan Summary Plan Description, copies of which is available from the Plan Administrator or his designee, upon your request. (See statement of ERISA rights.) If there is a discrepancy between the description of the Plan as contained in this material, and the official Plan Document, the language of the Flexible Benefit Plan Document will apply.

Forsyth County Schools Section 125, also known as Cafeteria Plan Summary Plan Description

Schedule A

Schedules Of Benefits

Forsyth County Schools Medical Reimbursement Account

Eligible Medical Expenses:

Employee Annual Contribution Limitations*

PayPeriod for Annual Payroll Contributions:

	Minimum	Maximum
TASC – Healthcare Flexible Spending Account	$300.00	$2,500

*Employee designated salary reduction and allocation subject to the limitations set forth.

**Employer contributions may be used as indicated in the Funding paragraph of Section 4. In no event may the Employer Contribution and the Employee Contribution together exceed the Employee Contribution Limitation above.

**The Employee contributions necessary to obtain the coverage's set forth in this Schedule A above will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period, as included in the Summary Plan Description of the Benefit. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

**Minimum to be determined by Plan Administrator and/maximums by allowed maximums. Minimum & Maximum Amounts calculated based on Proper Pay Period **Amounts to be insert above.

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Schedule B

Dependent Care Reimbursement Account

Employee Annual Contribution Limitations*

PayPeriod for Annual Payroll Contributions:

	Minimum	Maximum
TASC-Dependent Day Care Flexible Spending	$300.00	$5,000**

* Minimum Contribution as determined by the Employer.

** Maximum Contribution according to Internal Revenue Code Section 129 is $5,000 for a married couple filing a joint federal income tax report, or $ 2,500 for a married employee filing separately.

** Employer contributions may be used as indicated in the Funding paragraph of Section IV. In no event may the Employer Contribution and the Employee Contribution together exceed the Employee Contribution Limitation above.

** The Employee contributions necessary to obtain the coverage set forth in this Schedule B will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period, as included in the Summary Plan Description of the Benefit. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

** Minimum to be determined by Plan Administrator and/maximums by allowed maximums. Minimum & Maximum Amounts calculated based on Proper Pay Period.

Forsyth County Schools Section 125, also known as Cafeteria Plan Summary Plan Description

Schedule C

Premium Conversion Plan Reimbursement Account Annual Contributions

- The Employee contributions necessary to obtain the coverage options set forth in this Schedule C will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period.

  Required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option provided above.

  Participation in this Plan is conditioned upon the participant completing the paper or online **Enrollment Form** provided to each Participant at the time of your enrollment.

** **Benefit Programs. Dental and Vision**

*** **Coverage Tiers: Employee Only, Employee + 1 Dependent, Employee + Family**

List any Affiliated Employer who has adopted this Plan with name, address and phone numbers.
There are no other Employers affiliated with this plan.

Summary Plan Description

Appendix A.

Continuation of Coverage

In General. The following provisions shall apply to Benefits provided to Eligible Employees and their dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

Continuation of Coverage. To the extent required by Section 6 above, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;

B. in the case of a qualified beneficiary disabled during the first 60 days following the covered Employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination (that the disability must continue during the rest of the 18 months period,) within 60 days of the disability determination and within 18 months of the qualifying event; (Note: The right to the disability extension may be terminated if the SSA determines that the disabled qualified bgeneficiary is no longer disabled. The qualified beneficiary receiving the disability extension is required to notify the Plan Administrator if the SSA makes such a determination, and you must provide this notice within the 30 day period after the SSA makes such a determination. Such a notice is to be in writing and delivered in person, mailed or faxed to the Plan Administrator.

C. in the case of a qualifying event which occurs during the 18-months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, for the covered dependents, the date which is 36 months after the date that a covered Employee is terminated (except for gross misconduct), or the date that a covered Employee's hours are reduced;

(1) for plan years commencing on or prior to June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered Employee and that Employee's subsequent entitlement to Medicare while continuation coverage is in force for the qualified beneficiary, the date which is 36 months after the date of the covered Employee's entitlement to Medicare;

(2) for plan years commencing after June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered employee that occurs less than 18 months before the covered employee becomes subject to Medicare, the date which is the close of the 36 month period beginning on the date the covered employee became entitled to Medicare.

(3) If you are receiving an 18 month maximum period of continuation coverage, you may become entitled to an 18 month extension (giving you a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event that is the death of a covered employee, the divorce or legal separation of a covered employee and spouse, a covered employee's becoming entitled to Medicare or a loss of dependent status under the plan. . You are entitled to this continuation coverage period only if it would have caused you to lose coverage under the plan, in the absence of the first qualifying event. You are required to notify the Plan Administrator in the same manner as in Sec. B above.

D. in the case of any qualifying event except as described in A., B., and C. above, the date which is 36 months after the date of the qualifying event;

E. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any Employee;

F. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;

G. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event will coverage continue longer than the coverage period as set forth in this Section 6.4**.**

H. Your right of coninuation coverage under the Plan may be terminated prior to the end of your continuing coverage period if you engage in conduct that would justify the plan in terminating coverage of a similarly situated participant or bendficiary.

I. Your Plan Administrator is required to give you notice of Unavalability of Continuation Coverage should your rights of continuation coverage is denied or terminated. This Notice of Unavailability of Continuation Coverage will state the specific reason for denying your claim for continuation coverage. You will be notified of the date the coverage will terminate, and the reason for termination and the rights of the qualified beneficiary may have under the plan or applicable law, or to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Contribution.

A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer or a participating Employer in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay

such premium in monthly installments. Your election notice will contain complete information as to the amount of the premium required.

B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

D. Certain indivciduals may be eligible for a Federal Income tax credit as a result of the Trade Adjustment Assistance Reform Act of 2002 (HCTC). This tax credit helps pay for the premium of continuation coverage. You may be entitled to this tax credit (payable in some cases directly to the employer to offset the cost of the premium) if you lose your job due to the effect of international trade, and who qualify for trade adjustment assistance, as well as those receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). If you become entitled to this tax credit contact HCTC Customer Contact Center at 1-866-628-4282.

Notification by Qualified Beneficiary. Each covered Employee or qualified beneficiary must notify the Employer or a participating Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within 60 days after the date of such occur rence. This 60-day time limit shall only apply to those occurrences as described in this paragraph which occur after the date of the enactment of the Tax Reform Act of 1986.

Notification to Qualified Beneficiary.

A. The Employer or or a participating Employer shall provide written notice to each covered Employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

B. The Employer or a Participating Employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, Forsyth County Schools, shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies Forsyth County Schools of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

C. Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

Appendix A Definitions.

A. **"Dependents"** means an individual who meets the definition of dependent under the Participating Employer provided health plan covering the Eligible Employee. For the purposes of the Medical Reimbursement Plan, if any, dependents will also include individuals who are dependents within the meaning of section 152(a) of the Code, and as defined in section 1 hereof. No person shall be considered a dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by the Employer or a participating Employer, dependent children may be covered by either spouse, but not by both.

B. **"Election Period"** means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60 day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

C. **"Full-Time Student"** means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

D. **"Medicare"** means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

E. **"Qualified Beneficiary"** means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the dependent (as defined in Section 1 hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term qualified beneficiary includes the covered Employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who

Exception - the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code section 911(d)(2) and section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

F. **"Qualifying Event"** means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:
   (i) the death of the covered Employee;
   (ii) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered employee's employment;
   (iii) divorce or legal separation of the covered Employee from such covered Employee's spouse, as herein defined;
   (iv) the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
   (v) a dependent child who ceases to be a dependent child under the terms of this Plan;
   (vi) the Company's filing for Chapter 11 reorganization as it would affect retiree coverage.

G. **"University/College"** means an accredited institution listed in the current publication of accredited institutions of higher education.