THE BOARD OF EDUCATION OF JEFFERSON COUNTY, KENTUCKY
IRC SECTION 125 CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

(As Amended and Restated January 1, 2017)

The Jefferson County Board of Education ("Employer" or "Board") sponsors the Board of Education of Jefferson County, Kentucky IRC Section 125 Cafeteria Plan ("Plan"), which allows Eligible Employees to choose from a menu of different benefits and pay for those benefits with pre-tax dollars.

This Summary Plan Description ("Summary" or "SPD") describes the basic features of the Plan, how it generally operates, and how employees can gain the maximum advantage from it. This Summary is for general informational purposes only. It does not describe every detail of the Plan. You should refer to the official Plan documents for more extensive information. If there is a conflict between the Plan documents and this SPD, the Plan documents will control.

1. What benefits are offered under the Plan?

Premium Conversion for Group Insurance Programs. This feature allows you to pay the cost of group insurance programs with pretax dollars through payroll deduction. "Premium conversion" means that you are able to convert premiums you pay for group insurance benefits through payroll deduction from "after-tax" to "pre-tax," that is, from taxable to nontaxable premium payments. The available group insurance plans are health insurance, supplemental health insurance, dental insurance, cancer insurance, vision care insurance and accidental death and dismemberment insurance.

Health Reimbursement Arrangements and Flexible Spending Account Plans. The Commonwealth of Kentucky (the "State") administers flexible spending account plans (FSAs) for dependent care and health care benefits as well as health reimbursement arrangements (HRAs). Information regarding the FSAs and HRAs is not provided in this SPD; rather, you should receive or obtain separate information on these benefits from the State.

2. Who is eligible to participate in the Plan?

All full-time employees of the Board become Participants in the Plan on the first day of the second month after their date of hire. However, a full-time employee in a collective bargaining unit will become a Participant on the date specified in the applicable collective bargaining agreement; if no date is specified, they will become Participants as provided above.

Leased employees, temporary employees, part-time employees (less than 20 hours weekly), seasonal employees (less than 9 months annually), individuals classified by

the Board as independent contractors and other self-employed individuals are not eligible to participate in the Plan.

3. Who pays for the benefits?

Pretax Payroll Deductions. You pay for the nontaxable group insurance benefits you select with pretax payroll deduction. These pretax deductions are used to purchase your selected benefits in the following order: health insurance, supplemental health insurance, vision insurance, dental insurance, cancer insurance, accidental death and dismemberment insurance, a flexible spending account plan for health care, and a flexible spending account plan for dependent care.

The cost of each of the coverages you select is withheld from your paycheck in equal amounts based on 24 payroll periods each year. The Payroll Department will let you know the amount that will be deducted from each paycheck.

State Contribution. The State may make a contribution to a HRA for your benefit if you are eligible to participate in a State-sponsored health insurance plan for a given year. This State contribution is not controlled by the Board and may be modified or revoked at any time by the State. Any such contribution by the State to an HRA will not be made under the Plan, nor are the HRAs a part of the Plan.

4. What taxes can I save by participating in the Plan?

You do not pay federal or state income tax on your pretax payroll deductions. Not all Board employees (*e.g.,* KTRS participants) are subject to Social Security (FICA) tax, but even if you are subject to the tax, you do not pay FICA tax on your pretax payroll deductions. Because of these tax savings, you have more money to purchase benefits than you would if you had to purchase the same benefits with after-tax dollars. In most jurisdictions, you also do not pay local tax on these amounts.

Because you do not pay FICA tax on these amounts, you pay in less to Social Security over your lifetime and it is possible that your Social Security benefits could therefore be less than if you do not enroll in this Plan. For most people, the difference is negligible, but you should be aware of it.

5. Enrollment Procedure.

New Hires. New hires must complete an enrollment form and return it to Benefits Department - VanHoose Education Center *within 30 days of your hire date*. Your enrollment form includes an authorization for pretax payroll deductions to be made to cover the cost of the benefits you select. Deductions begin on the first available payroll period after your completed enrollment form is received. Your enrollment elections are effective for the entire calendar year. You cannot change your elections during the year except for certain changes in your circumstances discussed in Paragraph 7.

Annual Open Enrollment. You will be given an opportunity to change your benefit selections each year by completing a new enrollment form during the annual open enrollment period that takes place each Fall. The Board will notify you each year as to when the open enrollment period begins and ends. Your enrollment form will be effective January 1 of the following year and will remain in effect for that entire calendar year. You cannot change your elections during the year except for certain changes in your circumstances discussed in Paragraph 7.

Payroll Deduction Adjustments. Your payroll deduction for group insurance premiums is automatically adjusted if there is a change in the premium amount during the year.

Rehired Employees. If your employment ends and is reinstated within 30 days and during the same calendar year, your benefit elections in effect when your employment ended are automatically reinstated for the remainder of that year. If your employment is reinstated more than 30 days after your employment ends or is reinstated during a different calendar year, you are treated as a new hire and must make new elections within 30 days of the date you return to work. (See Paragraph 6 for details on default elections you are treated as having made if you do not make a timely election when rehired). The State controls the terms and conditions of reinstatement under the State health plans, the flexible spending account plans, and the HRAs described in Paragraph 3 under the heading "State contribution."

6. *What happens if I fail to timely complete an enrollment form?*

Default Elections. If you do not return a completed enrollment form to the Benefits Department within 30 days of your hire date, you are treated as having selected the default health insurance coverage established by the State for the remainder of the calendar year and to have waived all other benefit coverage. *See* Paragraph *5* for special rules that apply when your employment ends and you are rehired during the same year.

Automatic Elections. Once you begin participation in the Plan, if you do not complete an enrollment form and return it to the Benefits Department during the annual open enrollment period in any given year, you will be treated as having selected the same type and level of benefits you elected (or were deemed to have elected) in the previous year for all benefits except (1) the flexible spending account plans, for which you will be treated as having waived coverage, and (2) health insurance, for which you will be treated as having selected the default health insurance coverage established by the State.

Elections Irrevocable. Remember, your elections cannot be changed during the year except as provided in Paragraph 7. This also applies to the default and automatic elections you are treated as having made because you did not timely return a completed enrollment form to the Benefits Department. *It is therefore very important to timely return a completed enrollment form to the Benefits Department*

when you first become eligible and during open enrollment.

7. Can I change my election during the year?

Generally, no. Any election you make for a calendar year (including a default or automatic election as discussed in Paragraph 6) cannot be changed until the next open enrollment period. However, you may be able to change your benefit elections if one of the events described below occurs. There may also be additional reasons that would allow a change – consult the Benefits Department for more information. Any change to your benefit selections must be consistent with the event that permits the change.

Any change with respect to your State-sponsored health insurance, flexible spending account plan, or HRA is governed by rules established by the State, which will be honored by this Plan to the extent consistent with the IRS regulations governing mid-year election changes.

The Board may also change your elections if it is necessary for the Plan to comply with coverage and nondiscrimination requirements that apply to the Plan. You will be notified in advance if a change is required.

HIPAA Special Enrollment. You can change your election if you, your spouse, or your dependent become eligible for special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA). A special enrollment right can arise from certain losses of eligibility for health insurance, if a new spouse or dependent is acquired by marriage, birth, adoption, or placement for adoption, as a result of a loss of eligibility for Medicaid or state children's health insurance program (CHIP) coverage, and as a result of gaining eligibility for a state premium assistance subsidy under the plan from Medicaid or CHIP. Generally, you must request to change your election within thirty (30) days of the triggering event (a period of 60 days applies in situations involving a Medicaid plan or CHIP) and your election change will be effective no later than the first day of the first calendar month beginning after the date the Plan receives your request for special enrollment. Consult the Benefits Department if you think you qualify for special enrollment.

Court Orders. The Plan will honor any qualified court order requiring you to cover a dependent under the Board's group health plans, and you may cancel coverage for a dependent if the court orders your former spouse to cover the dependent and such coverage is actually provided.

Status Changes. You can change your elections under the Plan if one of the following status change events occurs and subject to the rules below:

- *Legal Marital Status*. Events that change your legal marital status, including, marriage, divorce, legal separation, annulment or death of your spouse;

- *Number of Dependents*. An event occurs that changes the number of your

dependents, including birth, adoption, placement for adoption, death of a dependent, or dependent status begins or ends due to age, student status, or a similar circumstance;

- *Employment Status*. Events that change the employment status of the you, your spouse, or your dependent, including:
    - (i) termination or commencement of employment;
    - (ii) strike or lockout;
    - (iii) commencement of or return from an unpaid leave of absence;
    - (iv) change in worksite; or
    - (iv) a change in you, your spouse, or your dependent's employment status that affects your eligibility under an employee benefit plan, including a cafeteria plan, including a switch from salaried to hourly or from hourly to salaried paid status, a reduction or increase in hours of employment, or a switch between part-time and full-time that affects that individual's eligibility under a benefit plan.
- *Residence Change*. You, your spouse or dependent's place of residence changes.

Election changes due to one of the above status change events are permitted only if the change is on account of and corresponds with the change in status event. This means, if the change in status is your divorce, annulment or legal separation from your spouse; your spouse or dependent's death; or if your dependent ceases to satisfy the eligibility requirements for coverage, you may only change your election to cancel coverage for your spouse or the dependent that loses eligibility because of the event. If a marital or employment status change results in you, your spouse, or your dependent becoming eligible for coverage under your spouse or dependent's employer's plans, you can only cease or decrease that individual's coverage under this Plan if that individual becomes covered or their coverage increases under the spouse or dependent's employer's plan.

Cost Changes. You may change your benefit election on a prospective basis for the following cost changes (note that tax rules to do not permit election changes to health care flexible spending accounts due to health care cost changes):

- If your share of the cost of coverage under a benefit option significantly increases during the year, either due to you having to pay a larger portion of the total cost of the benefit (*e.g.*, if part-time employee pays a greater share of the cost and you switch from full-time to part-time) or due to an increase in the total cost of the benefit, you may increase your pretax payroll deductions to cover the increased cost, elect another benefit option available under the

Plan that provides similar coverage, or drop coverage if no similar coverage is offered.

- If there is a significant decrease in the cost of a benefit during the Plan Year, you may make a corresponding change to your election to reflect the decreased cost, including changing your election to participate in the reduced cost benefit, even if you were not already participating in the Plan.

Coverage Changes. You may change your election on a prospective basis for the following coverage changes:

- *Addition Or Improvement Of Benefit Option*. If there is a significant improvement in the coverage provided under a benefit package option (*e.g.,* insurance co-payments are reduced by an amount which constitutes a significant benefit improvement) or a new benefit package option is offered during the Plan Year, you may change your election to elect that benefit coverage even if you were not previously participating in the Plan.

- *Elimination Of Benefit Option*. If coverage is eliminated during the year, you may revoke your election and elect another benefit option available under the Plan that provides similar coverage or you may drop coverage if no similar coverage is offered.

- *Significant Curtailment of Coverage*. If coverage is significantly curtailed during the year, you may revoke your election and elect another benefit option available under the Plan that provides similar coverage, and you may drop coverage if no similar coverage is offered and the curtailment amounts to a loss of coverage (*e.g.,* a major hospital ceases to be a member of a PPO network or there is a substantial decrease in the physicians participating in the PPO network (the loss of one particular physician in a network does not constitute a significant curtailment) or a reduction in benefits for a medical condition or treatment you are currently being treated for or any similar fundamental loss of coverage).

- *Addition Of Benefit Option*. You may elect a new benefit option that is added to this Plan or to your Spouse or your Dependent's employer's plan, and make corresponding changes to other benefit options.

- *Changes Corresponding to Open Enrollment Changes Made By Spouse or Dependent*. You may change your election to correspond with open enrollment period changes made by your Spouse (or former Spouse) or Dependent if your Spouse or Dependent employer's cafeteria plan has a different period of coverage.

- *Changes in Coverage Under Governmental Health Plan*. You may elect to participate in this Plan if you, your Spouse or your Dependent loses coverage

under a group health plan sponsored by a governmental or educational institution, such as a state program under the State Children Health Insurance Program ("SCHIP"). IRS regulations do not permit you to drop coverage when you, your Spouse or Dependent become eligible for SCHIP coverage during the year; however, you can always change your election at the next open enrollment period.

- *Changes Corresponding to Election Changes Made By Spouse or Dependent.* You may change your election to correspond to election changes made by your Spouse or Dependent under their employer's plan (*e.g.*, your Spouse or former Spouse's employer's plan adds a new HMO option and your Spouse or former Spouse elects that new option, you can change your election to drop healthcare coverage for the individuals actually added to your Spouse's employer's plan; the change must be on account of and correspond with the change made under the other employer's plan).

Entitlement to Medicare or Medicaid. You may cancel or reduce healthcare coverage, on a prospective basis, for yourself, your Spouse or your Dependent who enrolls in Medicare or Medicaid, or start or increase coverage for yourself, your Spouse or your Dependent when eligibility for Medicare or Medicaid coverage is lost.

Procedure To Change an Election. To change your election, complete a new enrollment form making the appropriate change and return it to the Benefits Department *within 30 days of the event that allows the change*. The change will be effective the first available payroll period after the Benefits Department receives, approves, and processes your new enrollment form (*see* special rule below for HIPAA special enrollments). *Requests for changes that are not submitted within the 30-day period will not be processed.*

8. What happens to my benefits if I go on a leave of absence?

Paid Leaves. Unless you change your election, your participation will continue with no changes during a paid leave of absence. Payroll deductions will continue to be taken from your paycheck during any paid leave of absence and you may continue to submit claims and withdraw money from your accounts.

Unpaid Non-FMLA Leaves. If the leave does not qualify under the Family and Medical Leave Act ("FMLA"), or if a collective bargaining agreement does not require otherwise, your participation will end during an unpaid leave of absence. If you wish to continue coverage while on an unpaid leave that does not qualify under FMLA, you may make arrangements with the Payroll Department prior to the beginning of your leave either to prepay contributions that will come due during your leave or to catch up on any contributions that came due during your leave after you return.

Unpaid FMLA Leaves. Unless you change your election (see Paragraph 7 for details on how to do that), your participation in all benefits continues during an unpaid

FMLA leave of absence. You have 3 options for paying payroll deductions that will come due while you are on an unpaid FMLA leave:

- *Pay As You Go*. You can mail your check to the Payroll Department but it must be received by the time your payroll deduction would have been made if you were working. Because the money is not coming from payroll deductions, it will be your after-tax money. If your payment is not received within 30 days from the due date, your coverage will end. The Board will send you a reminder notice at least 15 days before your coverage expires.

- *Prepay*. You can make arrangements with the Payroll Department before you go on leave to prepay (through advance pretax payroll deductions) all payroll deductions that will come due during the leave, with one exception -- if the leave begins in one year and ends in another, you can prepay payroll deductions that will come due for the current year but remaining payroll deductions must be paid when you return from leave (spread over no more than 6 payroll periods and deducted pretax).

- *Catch Up*. As long as your leave begins and ends in the same year, you can make arrangements with the Payroll Department before you begin the leave to pay all payroll deductions that come due during the leave when you return from the leave. Your payment will be spread over no more than 6 payroll periods and is deducted pretax provided there is a sufficient number of payroll periods left in the same year from which to do so.

  If your participation ends during an FMLA leave of absence and you return to employment as an Eligible Employee at the end of the FMLA leave, you will immediately become a Participant upon return from leave and your participation with respect to group health plan coverage under the Plan will recommence for the remainder of the Plan Year at the same rate per payroll period that was being deducted for such group health plan coverage before you went on FMLA leave. If the FMLA leave ends during a subsequent Plan Year, you must make new benefit elections.

Stopping Your Contributions When Your Leave Begins. A leave of absence is a change in family status that permits you to make a mid-year change in your election. (See Paragraph 7 for details on how to change your election). If you change your election to stop your contributions during your leave, your active participation will end. (See Paragraph 17 for information on what happens to the money in your account when your participation ends).

When Participation Is Not Continued During Leave. If your participation ends during your leave of absence and, after your leave of absence ends, you return to employment as an Eligible Employee, you will immediately become a Participant upon return from leave. Subject to any right to make a benefit election change, your benefit elections from before the leave will be reinstated either:

- with no break in coverage if your leave of absence is for a period of 31 days or less or if you are an Eligible Employee on any day during two consecutive months, even if you were on leave during the period in between;

- effective the first day of the second month after return from leave for the remainder of the Plan Year if your leave began and ended in the same Plan Year and the leave was not subject to COBRA or FMLA; or

- effective the first day of the month in which you return from leave for the remainder of the Plan Year if the leave began and ended in the same Plan Year and the leave is subject to COBRA or FMLA.

If your leave begins and ends in the same year, your benefit selections will automatically be reinstated at the same rate as before you went on leave. If your leave ends in a new Plan Year, your benefit selections as to insurance coverage will automatically be reinstated at the current rate for the new Plan Year unless you make new benefit elections.

To activate your participation, complete a new enrollment form and return it to the Benefits Department within 30 days after returning from leave. Your elections will be effective on the first day of the second month after the Benefits Department receives your completed enrollment form. (See Paragraph 6 "Automatic Elections" for details on what happens if you fail to timely return your enrollment form). If you continued your coverage through COBRA during your leave, or if your coverage was continued during an FMLA leave, complete a return from leave application to avoid a break in coverage.

Qualified Military Service. Contributions, benefits, and service credits with respect to qualified military service will be provided in accordance with Section 414(u) of the Internal Revenue Code. Contact the Benefits Department if you believe this section applies to you.

9. When will my participation in the Plan end?

Subject to the limited continuation of participation discussed in Paragraph 10, your participation in the Plan will end:

- on death;

- on termination of employment;

- when you cease to be an Eligible Employee;

- upon Plan termination;

- on the date you revoke your election to participate (subject to the rules discussed in Paragraph 7);

- or when you fail to make required contributions.

10. What happens to my benefits when my participation in the Plan ends?

The federal law known as COBRA requires most group health plans to give you and your family the opportunity to continue plan coverage when coverage is lost due to certain "qualifying events." Specific information describing COBRA continuation coverage can be found in the particular group health plan's summary plan description, which has been provided to you. If you need a copy of any group health plan's summary plan description, contact the Benefits Department.

11. Plan Amendment/Termination.

Although the Board expects to maintain the Plan, it has the right to amend or terminate all or any part of the Plan at any time for any reason.

12. Employer, Plan Administrator, and Agent for Legal Service of Process.

Jefferson County Board of Education
3332 Newburg Road
Louisville, KY 40218

EIN: 61-6001316

13. Applicable Law.

The Plan will be governed by and construed according to the laws of the Commonwealth of Kentucky except to the extent Kentucky law is preempted by federal law.

14. Plan Administration/Claim And Review Procedures.

The Board is responsible for administration of the Plan. If you feel you are being denied rights or benefits under the Plan, you may file a written claim with the Benefits Department, Jefferson County Public Schools, VanHoose Education Center, 3332 Newburg Road, Louisville, Kentucky 40218, (502) 485-3436. Any claim to be reviewed by the Board must be filed within 30 days of the event giving rise to the claim. Untimely claims will not be processed. The Benefits Department will notify you of the Board's decision in writing as soon as administratively practicable. The Board's decision is final and conclusive and binding on all persons.

These claims and review procedures apply only to the IRC Section 125 Cafeteria Plan. If you want to file a claim under the group insurance plans, please refer to your summary plan description for the group insurance plan for details on how to file a claim under those plans.

15. Plan Year.

The Plan Year is the calendar year.

16. *Newborns' and Mothers' Health Protection Act of 1996.*

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. 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 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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