

WYANDOTTE PUBLIC SCHOOLS UNINSURED HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

**TEACHERS
ADMINISTRATORS
SECRETARIES**

AMENDED AND RESTATED April 14, 2004

TO OUR EMPLOYEES

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the Wyandotte Public Schools Uninsured Health Care Plan.

You are urged to read this Summary Plan Description carefully and to acquaint your family with its provisions. This Summary Plan Description does not replace the provisions of the Plan document. The Plan document governs the operation of the Plan. Every effort has been made to make this Summary Plan Description as complete and accurate as possible, without making it overly technical. In the event of any difference between the Summary Plan Description and the Plan document, the terms of the Plan document will control.

If you have any questions about your benefits under the Plan, please contact the Human Resources Office.

DATED: April 14, 2004

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WHAT IS THE UNINSURED HEALTH CARE PLAN?

The Uninsured Health Care Plan provides reimbursement for Uninsured Health Care Expenses. Your uninsured health care expense account allows you to pay these qualifying expenses using "before-tax" income rather than "after-tax" income. This is accomplished by converting your elected pay reductions through the Wyandotte Public Schools Flexible Compensation Plan into the tax-free reimbursement of qualifying uninsured health care expenses.

All records of the Plan and all your elections under the Plan are based on the "plan year" which is the 12-month accounting period of the Plan. The plan year is the 12-month period from January 1 through December 31.

PARTICIPATION

This section describes the requirements for participation in the Plan. You may participate in the Plan only if you meet these requirements.

Eligibility to Participate.

You will be eligible to participate in the Plan on the first day of the month after you satisfy the following requirements:

- (a) A full-time employee of the Employer. "Full-time" means that you are regularly scheduled to work at least 32.5 hours per week.

PAY REDUCTIONS

As stated above, you can select uninsured health care expense benefits under the Uninsured Health Care Expense Plan by reducing your pay to purchase the benefits.

For each plan year, you may elect to reduce your pay for each pay period in an equal amount. Your **W-2** Form (which you use to compute your income taxes) will be reduced by the total amount of your pay reductions so you will not pay income taxes on this portion of your pay.

You can elect uninsured health care expenses in the space provided in your election form. Your election form will be provided to you during the open enrollment period (see the "Choosing Your Benefits" section below).

UNINSURED HEALTH CARE EXPENSE ACCOUNT

The Uninsured Health Care Plan operates by the Employer establishing a separate bookkeeping account in your name as the Uninsured Health Care Expense Account. The following briefly describes your uninsured health care expense account:

(a) **What Amount of Pay Reductions Should I Allocate to My Uninsured Health Care Expense Account?**

Whether to allocate any pay reductions to your uninsured health care expense account or the amount of pay reductions to allocate is entirely up to you. However, the maximum amount you may have credited to your uninsured health care expense account for a plan year (January 1 through December 31) is \$7,000.

If you know you will have qualifying medical expenses during the plan year which will not be covered by the Employer's group health insurance plan or by any other source, you should consider putting enough in your uninsured health care expense account to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying medical expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the amount of pay reductions to allocate to your uninsured health care expense account, it is wise not to put in too much. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. You have 45 days after the end of the plan year (December 31), to submit bills incurred during that plan year before all unused amounts are forfeited.

What Types of Expenses Are Eligible For Reimbursement From My Uninsured Health Care Expense Account?

Your qualifying medical expenses may be reimbursed under the Plan. Qualifying medical expenses may be incurred for:

- i. You;
- ii. Your Spouse;
- iii. A dependent you list on your federal tax return; or

- iv. A person you could have listed as a dependent on your federal tax return if that person had not received \$1,000 or more of gross income or had not filed a separate return.
- b) Qualifying medical expenses are only those types of medical expenses normally deductible on your federal tax return (without regard to the 7.5% of adjusted gross income limitation). They include, for example, expenses you have incurred for:
- i. Medicine, drugs, medically necessary birth control pills, vaccines, and vitamins your doctor prescribes.
 - ii. Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical only).
 - iii. Medical examinations, x-rays and laboratory service, insulin treatment and whirlpool baths the doctor ordered.
 - iv. Nursing help. If you pay someone to do both nursing help and housework, only the nursing help can be reimbursed as a qualifying medical expense.
 - v. Hospital care (including meals and lodging), clinic costs and lab fees.
 - vi. Medical treatment at a center for the treatment of alcohol or other substance abuse.
 - vii. Medical aids such as hearing aids, dentures, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs and guide dogs.
 - viii. Ambulance service and other travel costs to get health care. If you use your own car, you can claim what you spent for gas and oil to go to and from the place you receive the care, or you can claim nine cents per mile. You may add parking and tolls to the amount you claim under either method.

Many of the expenses listed above are covered by the Employer's group health insurance plan. Any expense covered by that plan or any other source will not be treated as a qualifying medical expense under the Uninsured Health Care Plan.

You CANNOT obtain reimbursement for any of the following expenses:

- i. The cost of health coverage. For example, you cannot obtain reimbursement for the premium you pay to obtain dependent health coverage under the Employer's group health insurance plan or for the premium your spouse pays to obtain health coverage under his or her employer's group health plan. You also cannot obtain reimbursement for the premium for an individual health policy. However, you can purchase dependent health coverage under the Employer's group health

insurance plan under other provisions of the Flexible Benefits Plan (see the "Pay Reductions" section above).

- ii. Life insurance or income protection policies.
- iii. The 1.45% hospital insurance benefits tax withheld from your pay as part of the Social Security tax.
- iv. Nursing care for a healthy baby. However, this expense may qualify for reimbursement under your dependent care assistance account.
- v. Illegal operations or drugs.
- vi. A trip your doctor told you to take for rest or change.
- vii. Cosmetic surgery, unless necessary because of injuries you received.

(c) **How Do I Make A Claim For Reimbursement?**

You should send your claims for reimbursement of qualifying medical expenses to the Employer or the benefit administrator the Employer has chosen. If a benefit administrator is chosen, you will receive written notification of the benefit administrator's name, address and telephone number.

Your uninsured health care expense account resembles an insurance policy. You are entitled to uniform coverage throughout the plan year. For example, if you incur \$100 of qualifying medical expenses in January, you may be reimbursed for those expenses immediately, even if you only have \$50 credited to your account during the month of January. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your uninsured health care expense account for the plan year. Also, only claims for qualifying expenses will be reimbursed. Reimbursement checks are issued twice per month. You must turn in your claim on a form provided by the Employer or its benefit administrator. You will need to provide the information required on the claim reimbursement form. This information includes the date each expense was incurred, the amount of the expense, the type of service, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the expense was paid, if applicable, and the insurance carrier explanation of benefits form. If your total claims for a month are less than \$25, those claims will be carried over into the next month. You will receive

reimbursement for those claims in the first month during which your total unpaid claims exceed \$25.

Claims for expenses incurred during a plan year can only be reimbursed out of your account balance for that plan year. All claims incurred during a plan year must be turned in no later than 45 days after the end of the plan year. If you do not turn in a claim by this date, the claim will be denied. Any amount then remaining in your account will be forfeited (see "Forfeitures" section).

Your account is not insured. You are liable for expenses incurred if for any reason the Plan or the Employer does not ultimately reimburse you for expenses that are eligible for reimbursement under the Plan.

OTHER RULES REGARDING YOUR UNINSURED HEALTH CARE EXPENSE ACCOUNT

(a) **Termination of Employment.**

If you terminate employment, you will be ineligible to have any additional pay reductions under the Plan credited to your uninsured health care expense account. If you have amounts remaining in your uninsured health care expense account, you may continue to turn in claims for reimbursement of expenses incurred before you terminated employment. You are not eligible to be reimbursed for claims occurring after you terminated employment unless you continue to participate in the Plan. Any claims must be filed within 45 days following termination to be eligible for reimbursement.

You may have the option of continuing to participate in the Plan after you terminate employment if you have not already received reimbursement for the entire amount you elected as uninsured health care expenses on your election form for the Plan Year. In order to participate, you make after-tax contributions to the Plan on a monthly basis in an amount equal to the pay reductions on a monthly basis which were allocated to your uninsured health care expense account before you left the Employer. This option is provided to you pursuant to a federal law known as "COBRA," and is only available to you until the last day of the Plan Year in which your termination of employment (or other qualifying event) occurs. Claims must be submitted in accordance with the time limits set forth elsewhere in this SPD. If your dependent is no longer eligible for coverage under the Plan, he or she also may be entitled to participate under the Plan through COBRA for the balance of the Plan Year. This election would require your dependent's after-tax contributions to the Plan.

If you do not elect to continue to participate, any amounts in your accounts after paying claims incurred while you were employed will be forfeited. Also, if you do not make the after-tax contributions on a timely basis, your participation will cease and any amounts in your accounts after paying claims incurred while you were a participant will be forfeited.

(b) **Forfeitures.**

The Plan operates on a plan year beginning on January 1 and ending on December 31. Your pay reductions for each plan year may only be used to reimburse qualifying expenses incurred during that plan year. You are not allowed to carry over any unused amounts to the next plan year. Federal law requires that any pay reductions left after reimbursing expenses incurred during the plan year must be forfeited. For purposes of the Plan, an expense is "incurred" when the service is rendered or the supply is provided.

Forfeiture will occur if you fail to use the entire amount in your uninsured health care expense account. You should be careful not to overestimate your expected expenses when you turn in your election form. It is better to pay some of your expenses with after-tax income than to overestimate your expected expenses and have forfeiture.

(c) **Appeal Procedure.**

If your claim for reimbursement is denied, in whole or in part, you will receive written notice of the denial of reimbursement from the Plan Administrator within 90 days after your claim is received unless special circumstances require more time for processing the claim. If more processing time is required, the plan administrator will give you written notice of the extension before the initial 90-day period is completed. The extension will not be longer than 90 days from the end of the initial period.

You may make a written request to the Plan Administrator for a review of the denial. Your written request must be made within 60 days after the mailing date of your reimbursement check or notice of denial. You may also have an authorized representative act for you. You, or your authorized representative, may: (1) request a review upon written notice to the Plan Administrator; (2) review pertinent documents; and (3) submit issues and comments in writing.

A decision on the review by the Plan Administrator will be made not later than sixty (60) days after receipt of your request for review, unless special

circumstances require an extension of time for processing, but in no event later than one hundred twenty (120) days after such receipt. The decision of the Plan Administrator shall be written and shall include specific reasons and pertinent Plan provisions on which the decision is based.

CHOOSING YOUR BENEFITS

This section describes the procedure for choosing benefits under the Plan. You must choose your benefits each plan year (January 1 through December 31) through the Wyandotte Public Schools Flexible Compensation Plan. You may not change your benefits during the plan year unless you have a change in family status.

Initial Benefit Selection.

You must complete an election form before the date that you become a participant in the Plan. The election must be in writing on a form provided by the Employer. The election will remain in effect through the last day of the plan year (December 31), unless you have a change in family status, as described below.

If you do not deliver an election form to the Employer before the date that you become a participant in the Plan, you will be deemed to have waived the uninsured health care coverage under the Employer's Flexible Compensation Plan for the remainder of the plan year. Instead, you will receive your full compensation for the remainder of the plan year through the Employer's regular payroll system.

Annual Benefit Selection.

You must also complete a new election form for each subsequent plan year and deliver it to the Employer during the open enrollment period announced by the Employer. The election will be effective as of the first day of the following plan year and will remain in effect through the last day of the plan year (December 31), unless you have a change in family status, as described below.

If you do not deliver an election form to the Employer during the open enrollment period, you will be deemed to have waived all non-Core benefits under the Flexible Compensation Plan for the next Plan Year. Instead, you will receive your full compensation for the next plan year through the Employer's regular payroll system.

Change In Benefit Election.

A change in your benefit election during a plan year can be made in limited circumstances. The change to your benefit election must be on account of a particular event, and satisfy any specific consistency rules that may apply to the benefit. A more detailed explanation of this provision is contained in the plan document.

The following are examples of changes in status:

- (a) Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;
- (b) Change in the number of your dependents, due to birth, adoption, placement for adoption, or death of a dependent;
- (c) Change in employment status for you, your spouse, or a dependent;
- (d) Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;
- (e) Change in residence for you, your spouse or dependent which affects your coverage; or
- (f) Change due to your commencement or termination of adoption proceedings.

Other circumstances that may cause, or permit, a mid-year benefit election change:

- (1) Insignificant cost changes to a qualified benefit (other than Uninsured Health Care accounts) may result in an automatic adjustment to your benefit election;
- (2) Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);
- (3) Significant curtailment of coverage;
- (4) The addition or deletion of benefit options;
- (5) A change in coverage in a spouse's or dependent's Section 125 Plan;

- (6) Termination of a Participant's employment followed by the re-hire of the Participant by the Employer;
- (7) A leave under the Family Medical Leave Act;
- (8) Applicability of a special enrollment period under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- (9) A COBRA qualifying event;
- (10) A judgment decree or other order of a court; or
- (11) The Participant becoming eligible (or losing eligibility) for Medicare or Medicaid.

If you have an event which may cause a change in election during a plan year, you may turn in a change in status request form to the personnel department within 30 days after the event causing the change in status occurs. Except as otherwise provided by law, the election in your change in status form will be effective for pay periods beginning after the form is approved by the personnel department.

ADMINISTRATION

An administrative committee of the Employer is the plan administrator. The plan administrator is charged with the administration of the Uninsured Health Care Plan. The plan administrator has the authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The plan administrator will exercise its authority in a uniform and consistent manner, based upon the objective criteria set forth in the Uninsured Health Care Plan. Further, the plan administrator has the authority to construe and interpret the terms of the Plan. The plan administrator may also hire third party claim administrators and benefit consultants to assist in the administration of the plan.

FUTURE OF THE PLAN

The Employer intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan at any time. However, no amendment or termination will take away your right to be reimbursed from pay reductions credited to your uninsured health care account at the time of the amendment or termination.

STATEMENT OF ERISA RIGHTS

As a participant in the **Wyandotte Public Schools Uninsured Health Care Plan**, you are entitled to certain rights and protections under the Employee 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 at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

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 this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain

certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

HIPAA PRIVACY STATEMENT

Privacy of Your Medical Information

This Plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act as set forth in 65 CFR Parts 160 and 164, as the same maybe amended from time to time (“HIPAA”), with respect to protected health information (“PHI”) as that term is defined in HIPAA. For purposes of the Plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information that relates to your and their eligibility for benefits under the Plan.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.

As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.

Other uses relating to plan administration which are approved in writing by the Plan Administrator or Plan Privacy Officer.

At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.

For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;

Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor; Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

Make its internal practices, book, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

If feasible, return, or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction to those purposes that make the return or destruction of the information infeasible;

Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

Business Manager and Business Office Staff

Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor determined above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

Mechanism Resolving Issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.

Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this Section III.

IV. Participants Rights

Participants and their covered dependents will have the rights set forth in the Plan's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan.

V. Privacy Complaints/Issues

All complaints or issues raised by Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator or the Plan's appointed Privacy Officer. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution to their complaint. The Plan Administrator or Privacy Officer shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator or Privacy Officer shall be final and be given full deference by all parties.

OTHER BASIC INFORMATION ABOUT THE PLAN

1. Plan Name: Wyandotte Public Schools Uninsured Health Care Plan

2. Employer's Name,
Address and Telephone
Number: Wyandotte Board of Education
639 Oak Street Wyandotte,
Michigan 48192 (313) 246-
1000

3. Employer's Taxpayer
Identification Number: 38-6004195

4. Plan Number: 502

5. Type of Plan: Uninsured Health Care

6. Type of Administration: Company Administration

7. Plan Administrator: Administrative Committee
Wyandotte Board of Education
639 Oak Street Wyandotte,
Michigan 48192

8. Name and Address of
9. Agent for Service of
Legal Process: Fiscal
Year of Plan: Administrative Committee
Wyandotte Board of Education
639 Oak Street Wyandotte,
Michigan 48192 January 1
through December 31

10. Open Enrollment Period: Before Year End

11. Effective Date for
Enrollment Change: January 1