

# BALDWINSVILLE CENTRAL SCHOOL DISTRICT

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## FLEXIBLE SPENDING ACCOUNT PLAN

### SUMMARY PLAN DESCRIPTION

(With Pre-Tax Insurance Premiums)

*Of the Provisions of the Plan  
in Effect on January 1, 2005*

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*Note that because the sponsoring employer has determined and advised EBS Benefit Solutions that this plan is a “government plan” or “church plan” exempt from the Employee Retirement Income Security Act of 1974 (“ERISA”), this form summary plan description does not conform with all ERISA requirements. In the event its determination is incorrect, the sponsoring employer is solely responsible for failing to comply with ERISA.*

*EBS Benefit Solutions, Inc. is providing this form summary plan description to assist the sponsoring employer with its obligations under the Employee Retirement Income Security Act of 1974 (“ERISA”), including its disclosure obligations to plan participants. However, the employer, as the plan sponsor and plan administrator, is responsible for the accuracy and distribution of the summary plan description to participants, and the overall operation of the plan. The employer should review the summary plan description carefully to ensure that it accurately reflects all of the terms and provisions of the employer’s plan. If it does not, the employer should make appropriate changes. The employer should also have the summary plan description reviewed by its own legal counsel for compliance with ERISA, tax requirements, and other applicable laws and regulations.*

## INTRODUCTION

This Summary Plan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection at the Human Resources Department, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027, during regular business hours.

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM"). Check to see if there are any SMM's attached when you refer to this SPD.

## IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

**Plan Name:** Baldwinsville Central School District  
Flexible Spending Account

**Plan Number:** 501

**Plan Type:** Cafeteria (Section 125) Plan

**Plan Year:** The Plan Year begins on January 1 and ends on December 31.

**Employer and  
Plan Sponsor:** Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027  
(315) 638-6047

**Employer Identification  
Number:** 15-6002126

**Plan Administrator:** Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027  
(315) 638-6047

**Type of Plan  
Administration:** The Plan is administered by the Employer through a Committee appointed by the Employer. All benefits are paid from the general assets of the Employer. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. The Human Resources Department is the primary source for information about these aspects of the Plan.

**Plan Agent for Service  
of Legal Process:** Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027

Legal process may also be served upon the Plan Administrator.

**1. What is the advantage to me of the Flexible Spending Account Plan?**

You can use the Plan to pay your premium for the group coverage listed in Question and Answer 4 on a pre-tax basis. (Your cost for the group coverage listed is referred to in this SPD as your “premium” whether the coverage is provided through an insured plan or is self-insured by your Employer.) You can also make pre-tax contributions to the Plan that can be used to pay or reimburse you for expenses described in Question & Answer 5. These amounts are deducted from your pay and are not reported as taxable income on your W-2 form, so you do not pay income tax or Social Security taxes on them.

Alternatively, under the Plan you will receive an additional amount in your paycheck per payroll period if you are eligible for, but decline and do not receive, the following group coverage:

- medical coverage

The additional amounts you receive in your paycheck are subject to income tax and Social Security taxes, and are reported as taxable income on your W-2 form.

**2. Who is eligible to participate in the Plan?**

You are eligible to participate in the Plan if you are:

an employee of the Employer.

Notwithstanding the above, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation (“LLC”), any member of the LLC; (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer.

### **3. When can I begin participating in the Plan?**

If you meet the eligibility requirements listed above, you may begin participating in the Plan:

immediately upon date of hire.

Once you are eligible to participate, your premiums will automatically be paid through the Plan unless you elect otherwise in a writing signed by you and filed with the Committee. If you file this election you will not be able to pay your premiums through the Plan until the next Plan Year, unless a change in status occurs that allows you to change this election (see Question & Answer 7). To make contributions to the Plan for other expenses you must complete the enrollment process. Failure to complete enrollment by the date specified by the Committee will be considered an election not to make contributions for the Plan Year for other expenses. In that case, you will not be able to make contributions for other expenses until the next Plan Year, unless a change in status occurs that allows you to change your election (see Question & Answer 7).

Your premiums and contributions to the Plan are deducted from your pay throughout the Plan Year.

For the Plan Year, see **IMPORTANT PLAN INFORMATION YOU SHOULD KNOW**.

### **4. What premiums can I pay through the Plan?**

You can pay your premiums for the following types of group coverage sponsored by your Employer:

- dental coverage
- medical coverage

### **5. What other expenses can be paid under the Plan?**

You can also make contributions to the Plan that can be used to pay or reimburse you for the following types of expenses, provided they are not payable or reimbursable from any other source:

- dependent care expenses that would otherwise qualify for a dependent care credit on your federal income tax return if they were not paid or reimbursed under the Plan.

- health care expenses (other than insurance premiums) that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of health care expenses required to take a deduction), and non-prescription medicines and drugs, such as antacid, allergy medicine, pain reliever and cold medicine purchased for you, your spouse or any person who qualifies as your dependent for federal income tax purposes. (Plan contributions cannot be used to pay or reimburse you for toiletries, cosmetics, sundry items, dietary supplements, vitamins and other items that are merely beneficial to a person's general health.)

**6. How much can I contribute for these other expenses?**

Before you can first participate in the Plan, and at the beginning of each Plan Year, you will be notified of the minimum and maximum amount you can contribute for that Plan Year.

**7. When can I change the amount I contribute to the Plan?**

You can change your elections before the beginning of each new Plan Year. Once the Plan Year has started, federal tax laws permit you to change your elections only when one of the following "changes in status" occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan of your Employer.
- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.
- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).
- Your premium increases significantly. (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but

does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- There is a significant curtailment in, or cessation of, your group coverage. (In the case of group health coverage, there must be reduced coverage for employees generally.) Note, that a significant curtailment in, or cessation of, your group coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.
- A new group coverage option is added or a group coverage option you have selected is eliminated. Note that the addition or elimination of a coverage option allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.
- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).
- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).
- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for coverage under the Plan or other employer plan providing the same type of benefits. However, if your employment terminates and resumes in the same Plan Year within a period of 30 days or less, your elections in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your elections.
- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note, a change in residence allows you to change the amount of the premiums you pay through the Plan for the group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- Your dependent's eligibility for health coverage changes due to the dependent's age, student status or marital status or similar circumstance.
- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.
- A person's status as a dependent for purposes of your dependent care election changes.
- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Plan.
- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan. Note loss of such coverage allows you to change the amount of premiums you pay through the Plan for medical coverage, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

**Note that any election change must be made within 30 days of an event described above, and must conform to and be consistent with that event.**

Also, even if you are allowed to change your health care expense reimbursement election, you may not reduce the annual contribution elected to less than the amount of health care expenses already reimbursed to you for the Plan Year.

#### **8. How do I receive my benefits from the Plan?**

Amounts are deducted directly from your pay and used to pay your premiums. Your employer may make arrangements for automatic payment or reimbursement of other expenses covered under the Plan. Otherwise, these expenses will be paid/reimbursed at least monthly, provided you file a written claim for payment or reimbursement at least five business days before a scheduled payment/reimbursement date.

The Committee will inform participants of the scheduled payment/reimbursement dates. Claims for payment or reimbursement must be made on forms provided by



the Committee. You may request forms from Human Resources, 29 East Oneida Street, Baldwinsville, New York 13027.

**Note:**

- The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Plan for dependent care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.
- The amount of health care expenses paid or reimbursed cannot exceed the amount of your health care expense contribution election for the Plan Year, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.
- Only expenses incurred on or after the date you begin participating in the Plan and before the date you stop participating in the Plan are covered under the Plan. Generally, you stop participating in the Plan when you are no longer an eligible employee of the Employer. (See Question and Answer 2.) In addition, except when the grace period discussed below applies (see Question and Answer 9), any expenses incurred after you stop making Plan contributions for those expenses are not covered.
- If you are employed through the end of the Plan Year, you have until the April 30<sup>th</sup> after the end of each Plan Year to submit a claim for payment or reimbursement for expenses that you incurred during the Plan Year or during the “grace period” for the Plan Year. (Question & Answer 9 discusses the grace period and Question & Answer 10 explains rules that apply when you terminate employment before the end of a Plan Year.)

By January 31 of each year, you will receive a statement showing the amount of your contributions to the Plan for the previous calendar year.

**9. What happens if I am employed by the Employer through the end of a Plan Year but my contributions for expenses (other than premiums) are greater than my actual expenses during the Plan Year?**

If the amount you contribute exceeds the expenses you actually incur during the Plan Year, plus the expenses you incur during the “grace period” for the Plan Year, you will forfeit the excess contributions. The grace period for a Plan Year is the 2-1/2 month period following the end of a Plan Year.

Expenses incurred during the grace period may be paid or reimbursed from a participant's account with contributions made for that Plan Year (to the extent those contributions have not already been used or are required to pay expenses actually incurred during the Plan Year) only if: (1) the claims for expenses incurred during the grace period are submitted no later than the April 30<sup>th</sup> following the end of the Plan Year; and (2) all other requirements and conditions for payment or reimbursement of the expenses are satisfied. If contributions for a Plan Year are greater than the amount paid for expenses incurred during that Plan Year (including expenses incurred during the grace period), the excess contributions are forfeited.

Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year.

Note that the grace period does not affect the rules regarding when expenses must be incurred, and when claims for expenses must be submitted, if a participant's employment with the Employer terminates before the end of a Plan Year.

**10. What happens if my employment terminates before the end of a Plan Year?**

You may claim payment or reimbursement for expenses incurred before your termination, provided you submit your claim for payment or reimbursement no later than 90 days after your termination. You may also have a right to COBRA continuation coverage. (See "COBRA Continuation Coverage" in Question and Answer 15.)

**11. What happens if I take a leave of absence during the Plan Year?**

A paid leave of absence is not itself a change in family status, so your elections will stay in place unless you have another reason to change them. However, a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your elections as explained in Question & Answer 7. Also, see Question & Answer 15 for special rules applicable to a leave under the Family and Medical Leave Act.

**12. Can the Employer amend or terminate the Plan?**

The Employer can amend or terminate the Plan at any time, but will notify you in advance. Amendment or termination of the Plan will not affect your right to payment or reimbursement for expenses incurred before the date of the change.

**13. Who controls the operation of the Plan?**

A Committee appointed by the Employer controls and manages the operation of the Plan. The Committee decides all questions arising in the interpretation and application of the Plan, and may establish rules for the operation of the Plan.

**14. What if I have questions about coverage or benefits, or want to make a claim for benefits?**

You should contact Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027 if you have questions about any group coverage sponsored by the Employer. Claims for group coverage benefits should be filed in accordance with the procedures applicable to that coverage. See Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027 if you need information on how to file a claim for a group coverage benefit.

You should contact Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027 if you have questions about the operation of this Plan.

If you disagree with a decision concerning your right to participate in the Plan or wish to make a claim for a benefit, you may file a claim in writing with the Committee. If you wish, you may appoint someone to file the claim and act on your behalf, provided you give the Committee signed written notification of the appointment. The claim procedure is different depending on whether the claim is related to a health care expense or is any other type of claim. If any part of the claim is denied, the Committee will provide you with a written notice, within 30 days after the receipt of a health claim or 90 days after the receipt of any other type of claim. However, if an extension is necessary due to reasons beyond the Committee's control, the time to make the determination may be extended for up to another 15 days for a health claim or 90 days for any other type of claim. (If an extension for a health claim is necessary because additional information is needed from you, then you will be given 45 days from the date you receive the notice to provide the information.) In any case, you will receive written notice of the reasons for the extension, any additional information required for the Committee to make the determination, and the date the determination is expected.

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; and (iv) a description of the Plan's review procedures and time limits. In

the case of a health claim, the notice will also state the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of health claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; and (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

**15. What additional rights do I have as a participant?**

Federal law gives you rights with regard to coverage and certain specific benefits. The following is a summary of those rights.

## **COBRA Continuation Coverage**

You may have a right under “COBRA” to continue to participate in the health care expense portion of the Plan only after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

#### When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

#### You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

#### How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage, which lasts no longer than the last day of the Plan Year in which the qualifying event occurs. Furthermore, COBRA continuation coverage is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to payment or reimbursement for health care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.

### If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contract or contracts identified below.

### Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027.

### **Health Insurance Portability and Accountability Act of 1996 and Uniformed Services Employment and Reemployment Rights Act**

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Information concerning your HIPAA and USERRA rights is available from Mr. William McKee, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York, 13027, phone (315) 638-6047, fax (315) 635-2120.

### **Family and Medical Leave Act**

If you are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue your contributions during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you

notify the Employer that you will not return to work. If you choose not to continue coverage during an FMLA Leave, you may resume Plan contributions when the FMLA Leave expires, provided you are still an employee eligible to participate in the Plan (see Question and Answer 2).

Information concerning your right to and obligations during a leave is available from Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027.

### **HIPAA Privacy Rights**

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact Mr. William McKee, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York, 13027, phone (315) 638-6047, fax (315) 635-2120.

### **Court Order or State Agency Notice Regarding Medical Child Support**

If the Plan receives a court order or notice from a state agency requiring you to provide a child or children with health coverage, you will be contacted about the procedure under which the Plan Administrator will determine if the order or notice satisfies certain requirements under federal law. If it does, the Plan must comply with the order or notice. Copies of these procedures are available, without charge, from Human Resources, Baldwinsville Central School District, 29 East Oneida Street, Baldwinsville, New York 13027.



**SUMMARY OF MATERIAL MODIFICATION  
TO THE  
BALDWINSVILLE CENTRAL SCHOOL DISTRICT FLEXIBLE SPENDING  
ACCOUNT  
SUMMARY PLAN DESCRIPTION**

This Summary of Material Modification describes changes to the Summary Plan Description for the Baldwinsville Central School District Flexible Spending Account (the "Plan"). After reading it, you should attach it to your copy of the Summary Plan Description.

*Definition of "Dependent" for Dependent Care Expense Account Claims*

You should have received an earlier summary of material modification explaining that the definition of "dependent" under federal tax law changed, effective January 1, 2005. The change was important because the only expenses that can be paid or reimbursed from a participant's account under the Plan are those incurred for the participant or the participant's spouse or dependent. Under the new definition, to be a dependent a person must be either a qualifying child or a qualifying relative.

- A qualifying child is the participant's child, brother, sister, stepbrother or stepsister (or a descendant of either) who has the same principal place of abode as the participant for more than one-half of the calendar year, is under age 19 (or a student under age 24) as of the end of the year, and has not provided more than one-half of his or her own support that year.
- A qualifying relative is a person who receives more than one-half of his or her support for the year from the participant, is not a qualifying child of anyone that year, and is the participant's child (or other descendant), son in-law, daughter in-law, brother, stepbrother, brother in-law, sister, stepsister, sister in-law, father, mother (or other ancestor), stepfather, father in-law, stepmother, mother in-law, aunt, uncle, niece or nephew, or someone (other than a spouse) who has the same principal place of abode as the participant and is a member of the participant's household (unless the relationship violates local law).

In addition, to be a qualifying relative for dependent care expense purposes a person could not have gross income for the year over a certain amount (e.g., \$3,200 for 2005).

The law has been changed again to eliminate the maximum gross income requirement for qualifying relatives. This means that Plan participants can now make claims for qualified dependent care expenses incurred for qualifying relatives (as defined above), without regard to the amount of gross income the qualifying relative has for the year.

