

MORGAN COUNTY BOARD OF EDUCATION
CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2016

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Consolidated Admin Services

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INTRODUCTION

Morgan County Board of Education (the "Company") established the Morgan County Board of Education Cafeteria Plan (the "Plan") effective January 1, 2016.

Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are employed by Morgan County Board of Education or any affiliate who has adopted the Plan. However, you are not an "Eligible Employee" if you are any of the following:

Covered by a collective bargaining agreement.

A leased employee.

A non-resident alien who received no U.S. earned income.

A part-time employee who is expected to work less than 20 hours per week.

You are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

Date of Participation

You will become a Participant eligible to receive benefits from the Plan on the first day of the calendar month next following the date you attain age 18 and you complete 30 days of service as an Eligible Employee.

However, you will become a Participant eligible to make contributions and receive benefits from the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

ELECTIONS

In General

When you become eligible to participate in the Plan, you may begin contributing to the Plan. Contributions pertaining to an account will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Election Procedures

When you are first eligible to participate in the Plan, you must return a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator.

After you are first eligible to participate in the Plan you will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you. In order to participate in the Plan for the next Plan Year, you must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you may modify elections at a time other than the beginning of a Plan Year.

If, as of the start of a Plan Year, you have not returned an election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

Modification of Elections

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A dependent satisfies or ceases to satisfy eligibility requirements.

Change in your place of residence.

Commencement or termination of an adoption proceeding.

Court judgment, decree, or order.

Entitlement to Medicare or Medicaid.

Significant cost or other coverage changes.

You take leave under the FMLA

You are permitted to revoke an election of coverage under a group health plan due to reduction in hours of service. In order to revoke an election of coverage under a group health plan due to reduction in hours of service, you must have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change. In addition, your revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

You are permitted to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace. In order to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace, you must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts as permitted by applicable law.

BENEFITS

Premium Conversion Account

When you become eligible to participate in the Plan, the Plan will establish a Premium Conversion Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. This account may be used to pay premiums on the contracts listed below:

Employer Group Medical

Employer Dental

Employer Vision

Employer Disability

Employer Group Term Life

Supplemental Plans

If a contract is offered in conjunction with a Company-sponsored benefit plan, you will be eligible to make contributions to the Premium Conversion Account only if you are also eligible to participate in the applicable Company-sponsored plan, it is described above and you are eligible to participate in this Plan.

In the event of a conflict between the terms of this Plan and the terms of a contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Care Reimbursement Account

When you become eligible to participate in the Plan, the Plan will establish a Health Care Reimbursement Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating in the Plan.

The entire annual amount you elect to contribute for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed will be available for reimbursement. The maximum amount you may contribute each year is the maximum amount permitted (\$2,550 for 2016).

Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Health Care Reimbursement Account. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded). You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Effective January 1, 2016, if you are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may receive a distribution from your Health Care Reimbursement Account. You must make the distribution during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year. The entire amount you elected for the Health Care Reimbursement Account for the Plan Year minus Health Care Reimbursement Account reimbursements received as of the date of the Qualified Reservist Distribution request can be withdrawn.

Dependent Care Assistance Account

When you become eligible to participate in the Plan, the Plan will establish a Dependent Care Assistance Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify if they allow you to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

Before and after school programs

Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)

Licensed child care center

Nursery school or pre-school

Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you will seek reimbursement will qualify as dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is \$5,000 (\$2,500 if you are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

You generally must file a Form 2441 to determine whether any part of your Dependent Care Assistance Account is taxable. Please note that participation in the Plan may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

COMPANY CONTRIBUTIONS

Amount

The Company may (but is not obligated to) make a contribution to help fund one or more of your accounts. If the Company decides to make a contribution, the amount of the contribution and the method used to allocate the contribution among various accounts will be determined by the Company at the time the contribution is made.

FORFEITURES

Plan Year/Termination

Except as provided below, any amounts remaining in your account at the end of the Plan Year will be forfeited after all claims are paid. In addition, any balance remaining in your account on the date you terminate employment with the Company will be forfeited after all claims are paid.

Any balance remaining in your Health Care Reimbursement Account at the end of any Plan Year up to \$500.00 will be carried forward and used to fund such benefits in any subsequent Plan Year. This carryover amount will not affect your ability to contribute the maximum amount (2,550) in the subsequent Plan Year.

CLAIMS

Deadlines

You must submit claims for reimbursement within 90 days after the end of the Plan Year.

Debit/Credit Cards

The Company will provide you with a debit, credit or other stored-value card for purposes of making purchases that may be reimbursed from your Health Care Reimbursement Account and/or your Dependent Care Assistance Account. The Plan Administrator will provide you with more information about stored value cards at the time you enroll in the Plan.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to Consolidated Admin Services at P.O. Box 1513, Cabot, AR 72023. The telephone number is 877-941-5956.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents or a representative of your estate.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial, and (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

- (1) Provide for a review that does not afford deference to the initial adverse benefit determination and that, if possible, is conducted by an appropriate representative of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- (2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate Plan representative will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- (4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant will lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, and (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

YOUR RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections. You have the right to:

Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts.

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 updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

In addition, the people who operate 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under the Plan.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done.

If you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order or national medical support notice, you may file suit in Federal and/or state court.

If you have any questions about the Plan, you should contact the Plan Administrator.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) and/or National Medical Support Notice. You may obtain a copy of the medical child support procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor is Morgan County Board of Education.
Its address is 1065 East Avenue, Madison, Georgia 30650.
Its telephone number is 706-752-4600.
Its Employer Identification Number is 58-6000292.
The Plan Administrator is Consolidated Admin Services.
Its address and telephone number is that of the Plan Sponsor listed above.
2. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code and, to the extent the Plan provides for Health Care Reimbursement Account benefits, the Plan is also a welfare benefit plan. The Plan number is 501.
3. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.
4. The Company's fiscal year and the plan year end on December 31.

V-3.00