DOWNERS GROVE SANITARY DISTRICT
FLEXIBLE COMPENSATION PLAN

SUMMARY PLAN DESCRIPTION

June 1, 2016

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GENERAL INFORMATION

Plan Name:	Downers Grove Sanitary District Flexible Compensation Plan
Plan Sponsor:	Downers Grove Sanitary District 2710 Curtiss Street Downers Grove, Illinois 60515-0703
Plan Sponsor EIN:	36-6000910
Plan Administrator and Agent for Service of Legal Process:	Downers Grove Sanitary District Attn: Assistant Clerk 2710 Curtiss Street Downers Grove, Illinois 60515-0703 630/969-0664
Claims Administrator:	Administrative Services Director Downers Grove Sanitary District 2710 Curtiss Street Downers Grove, Illinois 60515-0703 630/969-0664
Claims and Appeals Fiduciary for Disputed Claims:	District's General Manager Downers Grove Sanitary District 2710 Curtiss Street Downers Grove, Illinois 60515-0703 630/969-0664
Plan Funding:	The Plan is funded exclusively through payroll deductions from participants.
Plan Year:	June 1 through May 31

Abbreviations

For quick reference, this section provides a list of the abbreviations most commonly used in this booklet.

- "COBRA" means the Consolidated Omnibus Budget Reconciliation Act which governs the right to continue to participate in the HCA features of the Plan upon the occurrence of a "qualifying event."
- "DCA" means Dependent Day Care Account which is used to reimburse eligible expenses that you incur for the care of a child or adult dependent who is physically or mentally incapable of caring for himself or herself while you work.
- "FSA" means Flexible Spending Account to which you may contribute before-tax dollars to pay certain health care and dependent day care expenses.
- "HCA" means Health Care Account which is used to reimburse eligible expenses that you incur for certain medical, dental or other health care expenses that are not eligible for reimbursement through another source, such as your medical plan.
- "HIPAA" means the Health Insurance Portability and Accountability Act which governs special enrollment rights under the Plan.
- "SPD" means Summary Plan Description which is this booklet that provides a brief overview of Plan eligibility and benefits.
- "USERRA" means the Uniformed Services Employment and Reemployment Rights Act which governs the right to participate in the Plan during a leave to perform military service.

DOWNERS GROVE SANITARY DISTRICT
FLEXIBLE COMPENSATION PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The Plan, as amended and restated, is effective January 1, 2013.

The Downers Grove Sanitary District Flexible Compensation Plan (the "Plan") is a "cafeteria plan" maintained by the Downers Grove Sanitary District (the "District") for the benefit of eligible employees of the District.

Your FSA reimburses you for eligible health and dependent day care expenses.

The Plan offers a Flexible Spending Account to which you may contribute before-tax dollars to pay certain health care and dependent day care expenses. The Flexible Spending Account actually consists of two accounts:

- The Health Care Account, which reimburses you for certain medical, dental or other health care expenses that are not eligible for reimbursement through another source, such as your medical plan.

- The Dependent Day Care Account, which is used to reimburse you for eligible expenses that you incur for the care of a child or adult dependent who is physically or mentally incapable of caring for himself or herself while you work.

How to use this SPD. . .

This summary plan description ("SPD") has been organized to help you understand the benefits available to you. Following a brief overview of Plan eligibility and benefits, the SPD is divided into these sections:

- ***Your Flexible Spending Account:*** This section describes the Flexible Spending Account feature of the Plan, including reimbursement procedures and special rules applicable to the Health Care Account and Dependent Day Care Account, respectively.
- ***Enrollment:*** This section describes the requirements for receiving benefits and the process of enrolling in the Plan and becoming a participant.
- ***Paying for Your Benefits:*** This section tells you how you contribute your share of the cost of coverage to pay for your Plan benefits.
- ***Duration of Participation:*** This section describes the events that may cause your participation in the Plan to end.

- ***Plan Administration:*** Claims procedures and other administrative issues are addressed in this section.
- ***Miscellaneous:*** Plan provisions regarding amendment and termination of the Plan, and the effect of the Plan on your employment are described in this last section.

The Plan document, not this SPD, controls your rights.

The Plan is established according to a separate Plan document. This SPD describes the benefits provided by the Plan, effective January 1, 2013. ***While every effort has been made to make this SPD as accurate as possible, if there are any inconsistencies between this SPD and the Plan document, the Plan document will govern.*** Also, any questions concerning the Plan will be determined in accordance with the Plan document and not this SPD. The benefits and other provisions described in the SPD are effective only if you are eligible to participate in accordance with the terms of the Plan.

You may review or obtain a copy of the Plan. Please contact the Claims Administrator to examine or obtain a copy of the Plan.

OVERVIEW OF PLAN ELIGIBILITY & BENEFITS

Generally, you are eligible to participate in the Plan if you are in an employer-employee relationship with the District as a regular full-time or part-time employee.

When Are you Eligible to Participate?

If you are . . .

- employed in an employer-employee relationship with the District, and
- classified by the District as either a regular full-time employee regularly scheduled to work 40 hours or more per week, or a regular part-time employee who works less than 40 hours per week . . .

you are eligible to participate in the Plan as of the first payroll period following the date that you begin employment with the District.

If your participation in the Plan ends when your employment terminates and you are reemployed by the District later in the same year, you may be eligible to immediately re-enroll and make new benefit choices, if your reemployment qualifies as a "change in status" (as described later in this SPD).

A special rule may apply if your participation in the Plan ends when your employment terminates and you are reemployed by the District within 30 days. The Plan Administrator will contact you if the special rule applies to you.

If your participation in the Plan ends when your employment terminates and you are reemployed by the District in a subsequent year, you will be treated as a new employee for purposes of determining your eligibility to participate in the Plan.

Plan Benefits

The Plan offers one type of benefit:

Flexible Spending Accounts that allow you to use before-tax dollars to pay for your health care and/or dependent day care expenses.

If you are eligible to participate in the Plan, you can choose the benefit features that you want to participate in so that your benefits package best suits your needs and the needs of your family.

You pay for the benefits you receive under the Plan using before-tax contributions that you make to the Plan.

Descriptions of each of the benefit features and payment options follow in this SPD.

YOUR FLEXIBLE SPENDING ACCOUNT

You set aside before-tax dollars to pay certain expenses.

The Plan offers a Flexible Spending Account, or "FSA," feature. When you enroll in the Plan, you can elect to participate in the FSA. The Plan Administrator will then establish an FSA in your name. Amounts credited to your FSA will be used to reimburse you for eligible health care and dependent day care expenses, as described below.

FSA = Health Care Account and/or Dependent Day Care Account

Your FSA actually consists of two separate accounts:

- your ***Health Care Account*** **or** ***"HCA,"*** which is used to reimburse you for eligible health care expenses that are not paid through the medical plan or other sources, and
- your ***Dependent Day Care Account*** **or** ***"DCA,"*** which is used to reimburse you for eligible expenses you incur for the care of your child or adult dependent so that you can work.

Funds cannot be transferred between accounts.

Although they are both maintained through your FSA, your HCA and DCA are <u>separate</u> accounts that are subject to different rules and restrictions. Amounts credited to your HCA may not be used to reimburse you for your dependent day care expenses, and amounts credited to your DCA may not be used to pay your health care expenses.

Your HCA pays certain expenses that are not covered by your medical plan.

Your HCA

Some medical and dental expenses that you or your family incur may not be covered by your medical plan. For example, you may be responsible for plan deductibles and co-payments, as well as any expenses in excess of "reasonable charge" limits. In addition, certain medical procedures or treatments may be excluded from coverage entirely. The Plan offers you an opportunity to pay some of these expenses with before-tax payroll contributions that you allocate to your HCA. Your HCA may be used to pay your health care expenses, provided that they are not reimbursable from any other source and that they are eligible under IRS guidelines.

Contact the Plan Administrator for a more complete list of reimbursable and non-reimbursable expenses.

Examples of Reimbursable Health Care Expenses:

- Health plan deductibles
- Health plan co-payments
- Orthodontia (*i.e.* braces) and other dental care expenses
- Vision care, including eyeglasses and contact lenses
- Hearing aids
- Expenses for medically necessary treatments and procedures that are not covered by a health plan
- Stop-smoking programs and the cost of prescription drugs that are designed to help you stop smoking
- Weight-loss programs undertaken at a physician's direction to treat an existing disease

Examples of Non-Reimbursable Expenses:

- Cosmetic surgery expenses (except to correct congenital abnormality, personal injury or disfiguring disease)
- Expenses incurred in connection with an illegal operation or treatment
- Health club dues
- Vitamins taken for general health purposes
- Transportation expenses to and from work, even though a physical condition may require special means of transportation
- Nonprescription drugs

An HCA expense must be eligible.

In short, the HCA reimburses you for any health care expense that is eligible. But remember, expenses reimbursed by your HCA may not be claimed as a deduction on your income tax return.

Eligible Dependents Under Your HCA

You can use your HCA for your dependents' expenses.

You can use your HCA for expenses for both yourself and your eligible dependents. Your dependents *do not* have to be covered under your medical plan for you to claim reimbursement from your HCA for expenses that you incur for their care.

Your dependents include your spouse, your children and your parents.

For purposes of the Plan, your dependents include:

- your current legal spouse
- your children and your spouse's children who:
  - are under age 19
  - are under age 25 and full-time students
  - are covered by the Plan when they attain the age limits discussed above but who are mentally or physically incapable of supporting themselves
- your parent and your spouse's parent if the parent is living with you when the expenses are incurred and will be living with you for the foreseeable future, and you can claim the parent as a dependent on your tax return.

Contributions to Your HCA The maximum annual amount of before-tax payroll reduction contributions that you may allocate to your HCA is ***$2,340.***

Your DCA

Your DCA covers expenses you incur for the care of a dependent while you work.

The DCA reimburses you for some or all of the expenses you incur for the care of a child or disabled dependent while you work. If you are married and live with your spouse, you will only be eligible to contribute to a DCA if your spouse works, attends school full-time or is a ***"qualified dependent"*** (as described below).

Choosing Between the DCA and Income Tax Credit

You must choose between the DCA and a federal tax credit.

The dependent day care expenses that are reimbursable from your DCA are the same expenses that may qualify you for a credit on your federal income tax. ***However, you cannot take a tax credit for dependent day care expenses that are reimbursed from your DCA.*** For most people, paying day care expenses through a DCA is more advantageous than paying the expenses directly and taking a tax credit.

The approach that offers you the better financial advantage will depend on your income and expenses. Your local IRS office can also provide you with any additional information that you need to make a decision. Finally, you may want to get advice from your professional tax advisor.

Dependents include children under 13 and disabled adults.

Qualified Dependents Under Your DCA

You may only receive reimbursement from your DCA for expenses related to the care of your ***"qualified dependents."*** A qualified dependent is either:

- your child under age 13 whom you are entitled to claim as an exemption on your federal income tax return, or
- your spouse or other dependent (of any age) who is physically or mentally incapable of caring for himself or herself.

Examples of Reimbursable Expenses

You can use the DCA to pay for care provided inside or outside your home.

- fees for child care centers and nursery schools
- pay for day care providers and baby sitters
- expenses for the care of disabled dependents

Dependent day care fees paid to your own family members are not eligible for reimbursement unless the family member is over age 19 and not claimed as a dependent on your federal income tax return.

Contributions to Your DCA

Generally, you can put up to $5,000 in your DCA.

If you elect to participate in the DCA, the maximum annual amount that you may allocate to your DCA is an amount equal to the lesser of:

- ***$5,000 ($2,500*** if you are married but file your federal income tax return as a single individual); or
- if you are single, the amount you are paid by the District for the year; or
- if you are married, the lesser of the amount you earn for the year and the amount that your spouse earns.

For each month that your spouse is either a full-time student or incapable of caring for himself or herself (or your other qualified dependents), he or she will be considered to earn an income of $200 ($400 if you have two or more dependents), up to an annual maximum amount of $4,800.

You can contribute before-tax pay to your FSA.

Contributions to Your FSA

When you enroll to participate in an FSA, you must elect in writing the amounts that you want to contribute to your HCA and DCA. You may choose to contribute to either one or both of the accounts offered under the FSA.

Your FSA contributions will consist of amounts taken directly out of your regular paychecks on a before-tax basis.

See the "Paying for Your Benefits" section of this SPD for more details on how you pay for your benefits under the Plan.

When Eligible Expenses Must Be Incurred

To be reimbursed from your FSA in any plan year that you have elected to participate, your eligible expenses must be incurred after the later of:

This is when your "period of coverage" under the Plan begins.

- June 1 , and
- the date you start participating in the FSA either because you are a new employee or as a result of a change in status.

Additionally, you must incur the expenses before the earlier of:

This is when your period of coverage ends.

- August 15 of the year immediately following the end of the plan year. and
- in the case of the HCA, the end of the pay period in which your contributions stop for any reason.

WHEN YOU RECEIVE A BILL FOR EXPENSES THAT ARE REIMBURSABLE FROM YOUR FSA:

Claims for reimbursement from your FSA should be submitted directly to the Claims Administrator <u>after</u> you have incurred the expense.

- **Pay the service provider directly. Be sure to keep a copy of the bill. If you are purchasing medicines or other medical equipment, be sure to get a receipt.**
- **Obtain a claim form from the Claims Administrator.**
- **Send the completed form, along with any documentation described on the form, directly to the Claims Administrator. (See General Information on page i.)**

You will be reimbursed directly from your FSA.

Claims will be processed monthly. You will be reimbursed for claims for eligible expenses submitted on the appropriate forms and accompanied by acceptable documentation. Payment will be made directly to you and not to any service providers.

Different rules apply to each account.

Reimbursements from Your HCA and DCA

Your HCA and DCA each impose different rules on when and how claims are paid.

You do not have to have enough money in your HCA to get reimbursed.

HCA Expenses: You will be reimbursed for your eligible expenses as you submit claims for such expenses, ***regardless of the actual balance in your HCA, as long as the claim is received within one hundred fifty (150) days after the plan year ends.*** You will continue to be reimbursed for eligible expenses until your total reimbursements equal the amount you elected to contribute to your HCA for the year.

You may not have a negative balance in your DCA.

DCA Expenses: As you submit requests for dependent day care expenses, you will be reimbursed for all proper claims, ***up to the actual amount that is credited to your DCA when the claim is received.*** If the balance in your DCA is less than the amount of a claim, the claim will be held and reimbursed after additional contributions sufficient to cover the full amount of the claim have been deposited in your account.

In order to be reimbursed from your DCA, you must be able to provide your dependent day care provider's:

- Name,
- Address, and
- Employer Identification or Social Security number.

Claim forms are available from the Claims Administrator that must be used to validate your dependent day care expenses.

"Use-It-or-Lose-It" Rules

As explained above, you will decide how much to contribute to your FSA. Because you make this decision when you enroll in the Plan (before you have incurred your expenses for the year), it is possible that you may overestimate your expenses and contribute more than you need to cover your health care and/or dependent day care expenses.

You cannot "carry over" contributions to your FSA from one year to the next.

The tax laws require that all amounts that you contribute to your FSA during the year must be used to reimburse eligible expenses that you incur during the same year and up to August 15 of the year following the end of the plan year. If you overestimate your expenses, the tax laws require that any unused before-tax contributions be forfeited.

You may not use excess amounts left in your HCA to pay your dependent day care expenses, and vice versa, even if you will otherwise forfeit those amounts.

The tax laws make it very important for you to carefully estimate your expenses.

That is why you must carefully estimate your health and dependent day care expenses when you elect to participate in the Plan. ***If you budget for emergencies or rare occurrences and they do not occur, you will be likely to end up losing the money.***

ENROLLMENT

Elections you make during the initial enrollment period are good for 12 months.

Initial Enrollment Period

There will be an initial enrollment period during which you may elect to participate in the Plan, effective January 1. Your elections will remain effective until December 31 of that Plan Year.

You must re-enroll in the Plan every year for the FSA benefit.

Annual Enrollment

After the initial enrollment period is over, future enrollment periods will be held on an annual basis. The District will determine the length of all enrollment periods for the Plan. During an enrollment period, you may enroll in the Plan by submitting all required forms to the Claims Administrator before the enrollment period ends.

If you are participating in the Plan and you do not re-enroll in the FSA during a subsequent annual enrollment period, no contributions to the FSA will be made for you. You must submit an enrollment form during the annual enrollment period in order to participate in the FSA for the applicable year.

If you are not eligible to enroll in the Plan during the initial or any subsequent annual enrollment period, you may apply to enroll within 60 calendar days after you become eligible. If you enroll during this 60-day period, your coverage under the Plan will be effective as of the date you became eligible. Otherwise, you will have to wait until the next enrollment period to begin participating.

Changing Your Elections

Your Plan elections are valid for an entire year. You will not be allowed to change or revoke your elections until the next enrollment period or during a plan year following a "change in status" (as discussed below). This is because the IRS requires that you commit to participating in the Plan for the entire year in order to receive the tax advantage of paying for your medical plan premiums, and health care and dependent day care expenses with before-tax dollars.

However, the IRS does provide exceptions that allow you to change your elections mid-year. You may change your Plan elections if you experience a change in status, or if you experience a special event that entitles you to make new elections under the Plan.

You may change your elections to reflect changes in your family or employment.

Change in Status: The IRS currently defines a change in status as one of the following events:

- a change in your marital status, including your marriage, legal separation, divorce or annulment,
- the death of your spouse or child,
- the birth, placement for adoption or adoption of your child,
- the commencement or termination of employment by you, your spouse or dependent,
- a reduction or increase in the hours of employment worked by you, your spouse or other dependent, including a switch between part-time and full-time employment, a strike or lockout, or the commencement or return from an unpaid leave of absence, or
- any event that results in your spouse or child(ren) no longer satisfying the requirements for coverage under the District's medical plan in which they are enrolled for the Plan Year.

You may only change your elections to make them consistent with your new situation.

Please note, however, that any change in your Plan elections must be consistent with the change in status that you experienced. The Plan Administrator, in its sole discretion, will determine whether your elections are consistent with your change in status.

The Plan Administrator may require you to provide proof of your change in status, such as birth certificates, divorce decrees, etc.

You can change your Plan elections in these situations, even if they do not qualify as changes in status.

Other Special Events: In addition to the changes in status described above, you will also have an opportunity to immediately change your Plan elections (including an election to not participate in the Plan) in any of the following events:

- You acquire special enrollment rights under the District's medical plan due to your loss of other health coverage or the addition of a dependent, as provided under the Health Insurance Portability and Accountability Act ("HIPAA"). See the Plan Administrator or the SPD for the District's medical plan

for more information regarding your rights under HIPAA.

- You or your dependent (including your spouse) become enrolled for coverage under Medicare or Medicaid (other than under a program solely providing pediatric vaccinations) or loses such coverage.

As with a change in status, any change in your Plan elections that you are allowed to make as a result of one of the above events must be consistent with the event and, if applicable, permitted under the terms of the medical plan. The Plan Administrator, in its sole discretion, will determine whether the change in your elections is consistent with your situation.

You must report a change in status or other event within 30 days in order to change your elections.

How to Change Your Elections: If you experience a change in status or other event described above and you want to change your Plan elections as a result, contact the Claims Administrator as soon as possible to obtain new Plan enrollment form. ***The form must be returned no later than 30 days following the date that the change in status occurred.*** Any change in your contributions will become effective with the earliest possible pay period after your form has been received.

If you do not notify the District within 30 days of a change in status, you must wait until the next enrollment period to change your Plan elections.

PAYING FOR YOUR BENEFITS

You pay for Plan benefits using your money.

You will pay for the benefits you select when you enroll in the Plan by using amounts taken directly from your regular paychecks on a before-tax basis.

Your contributions are taken directly out of your paycheck and contributed to the Plan.

Your contributions to the Plan (if necessary) are made through automatic payroll deductions. The District will divide the total amount that you need to contribute for the year by the number of regular paychecks you expect to receive. The District will then deduct equal amounts from your pay over the course of the year and contribute such amounts to the Plan to pay for your benefits.

Before-Tax

The District will deduct your Plan contributions from your before-tax pay.

The value of tax benefits will vary for each person.

Tax Benefits

If you make before-tax contributions to the Plan, you will reduce the amount of your income that is subject to taxes. As a result, your federal (including FICA) and state income taxes will be reduced, making more of your paycheck available for you and your family.

Please remember, however, that the income tax laws change frequently, and these changes may affect different individuals in different ways. ***Therefore, the District cannot assure you that it will be to your advantage to participate in the Plan.***

Paying lower Social Security taxes may mean a slightly reduced Social Security benefit. Contributing less to the Illinois Municipal Retirement Fund may mean slightly reduced pension payments.

Possibility of Lower Social Security or Pension Benefits

Your before-tax contributions to the Plan may also have an effect on the amount of Social Security benefits you will receive later in life. If you earn less than the Social Security "taxable wage base" ($113,700 in 2013) after making contributions to the Plan, your before-tax contributions to the Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may in turn cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your before-tax contributions and how long you participate in the Plan before you retire. Similarly, your before-tax contributions to the Plan may reduce the amount of your contributions to the Illinois Municipal Retirement Fund. As a result, your pension payments may be slightly lower. You should consult with your financial advisor about the effects of your participation in the Plan.

Highly compensated employees may have their before-tax contributions reduced.

Restrictions on Benefits Provided to Highly Compensated Employees

The law may limit the amount of before-tax contributions that highly compensated employees may make to the Plan. These limits are intended to prohibit the Plan from discriminating in favor of highly paid individuals. The Plan Administrator may have to reduce or return the before-tax contributions of participants who are highly compensated. If you are affected by these limits, the Plan Administrator will notify you.

DURATION OF PARTICIPATION

Your participation ends when your employment, your eligibility or the Plan terminates, whichever occurs first.

When Does Your Participation End?

Once you elect to participate in the Plan, you will continue to participate until the earliest of:

- the date you are no longer eligible to participate in the Plan for any reason, including the termination of your employment;
- the date on which you fail to make any "Required Contribution" (as described below);
- the last day for which your election to participate in the Plan remains effective; or
- the date this Plan is terminated.

When your participation in the Plan ends, your Plan benefits will generally cease, except as follows:

- You may have the right to continue your participation by electing continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to your coverage under your HCA, but not your DCA. See the "COBRA Rights" subsection of this SPD for more details.
- If your participation in the FSA terminates for any reason, you may be entitled to receive ***"termination benefits."***
  - You may receive reimbursement from your HCA for the eligible health care expenses that you incur up until the date that your participation in the HCA terminates.
  - You may receive reimbursement from your DCA for the eligible dependent care expenses that you incur at any time during the calendar year in which your participation ends, even if you incur the expenses after your participation in the DCA terminates. You will be reimbursed for all eligible expenses, up to the balance credited to your DCA when your employment terminates.

  You, or, in the event of your death, your beneficiaries, have up to 90 days into the Plan Year following the year in which your participation terminates to submit your expenses for reimbursement. On September 1, any balance remaining in your FSA will be forfeited.

You may be able to participate in the Plan while on leave.

Effect of Leaves of Absence

Your right to continue your participation in the Plan while you are on a leave of absence varies, depending on the type of leave you take. However, there are certain rules that apply, regardless of the type of leave you take:

These rules apply to all types of leaves.

- If you choose to participate in the Plan during your leave, you will be allowed to change your Plan elections in accordance with the "Changing Your Elections" rules described earlier in this SPD.
- You must notify the Plan Administrator of any leaves of absence that you plan to take. The Plan Administrator will then provide you with the appropriate forms for continuing or revoking your participation.
- While you may be eligible to continue your participation in the Plan during your leave of absence, you are not required to do so. You may instead revoke your election to participate. If you do, your participation in the Plan will end on the last day of the month in which your leave begins.

If you revoke your election to participate in the Plan during your leave of absence and return to active employment in the same year, you will be allowed to re-enroll in the Plan as long as your return to active employment qualifies as a change in status, as described earlier in this SPD. Otherwise, you will have to wait until the next enrollment period to resume participation (unless you took a military leave, as described below).

Some rules depend on the type of leave.

Paid Leave of Absence

If you take a paid leave of absence, you may continue to participate in the Plan during your leave. You will be eligible to make contributions as though you were still actively employed.

Unpaid Leave of Absence

If you take an unpaid leave of absence for any reason, you may continue to participate in the Plan during your leave, provided that:

- the District considers you to be an employee of the District, and
- you make any ***"Required Contributions."***

"Required Contributions" are the amounts necessary to pay for your continued participation in the Plan during your leave of

absence. Your Required Contributions should equal the before-tax contributions that would be taken from your regular paycheck if you were actively employed and participating in the Plan, unless the cost of your benefits changes as a result of your leave.

You make your Required Contributions in the following way:

After Tax Contributions on a Pay-As-You-Go Basis: You may make your Required Contributions on an after-tax, pay-as-you-go basis. Under this method, you will pay the District for the cost of participating in the Plan during your leave. Payments that you make on this basis will not be excluded from your taxable income.

Before-Tax Contributions on a Pre-Pay Basis: You may make your Required Contributions on a before-tax, pre-pay basis. Under this method, the District will withhold your Required Contributions for the period of your leave, from amounts owed to you by the District. Payments that you make on this basis will be excluded from your taxable income. Under this method, you cannot pre-pay any Required Contributions for periods extending beyond the close of the Plan Year in which your leave begins.

USERRA is a military rights law that entitles you to special treatment under the Plan.

Military Leave

Notwithstanding any other provision of the Plan or this SPD, if you take a paid ***or*** unpaid leave of absence under either the Uniformed Services Employment and Reemployment Rights Act, or ***"USERRA"*** (to perform military service), you will have the same right to continue your participation in the Plan during your leave as described above for paid and unpaid leaves (as the case may be). If you revoke your participation in the Plan during your leave and then return to active employment in the same year, ***you may immediately re-enroll in the Plan.***

The Plan Administrator can provide you with more information about your rights under USERRA.

Termination of Employment

Generally, your participation in the Plan will end if your employment with the District terminates, except as provided under COBRA (as explained below).

FSA Benefits Following Termination

You may receive reimbursements from your FSA following the termination of your employment, as follows:

- *Health Care Account:* You will be reimbursed for eligible expenses that you incur prior to the date your employment terminates.

- *Dependent Day Care Account:* You will be reimbursed for eligible expenses that you incur at any time during the year in which your employment terminates, up to the balance in your account when your employment terminates.

COBRA Rights

Generally, you and/or your spouse and eligible dependents will not be able to continue participation in the HCA on an after-tax basis under COBRA unless, as of the date of your qualifying event (such as your termination of employment with the District), the amount of claims you have filed for reimbursement from your account for the Plan Year are less than the amount you have already contributed to the account for that Plan Year. Contact the Plan Administrator if you would like more information about any COBRA rights you may have with respect to your HCA.

Your right to continue to participate in the Plan following the termination of your employment is determined under federal law and under the terms of the documents which govern any underlying benefit plans and programs. The Plan Administrator can provide you with more information about your rights under federal law.

PLAN ADMINISTRATION

The Plan Administrator has the discretionary authority to interpret the Plan and to make factual determinations as to all Plan matters.

The District is the Plan Administrator of the Plan. The Plan Administrator has the sole discretion and authority to administer the Plan, to interpret the terms of the Plan and to decide all matters arising in connection with the administration of the Plan. This includes the discretionary authority and power to make factual determinations and to determine all matters relating to eligibility, enrollment, coverage and termination of coverage.

The Plan Administrator also has the sole and exclusive authority to carry out all actions regarding claims for benefits under the Plan. The Plan Administrator may adopt uniform rules for the administration of the Plan as it deems necessary or appropriate. The decisions of the Plan Administrator will be final and conclusive with respect to all questions relating to the Plan.

No person has the authority to make any verbal statements of any kind at any time that are legally binding on the District or the Plan, or alter the actual Plan document and contracts maintained in connection with the Plan.

Claims should first be submitted to the Claims Administrator.

Claims Procedures

Claim forms may be obtained from the Claims Administrator. When completed, the forms should be sent directly to the Claims Administrator.

Filing a Claim — You should not file a claim under this Plan in order to obtain coverage under the medical plan; those claims should be filed under the medical plan. You will, however, submit claims under this Plan, for example, for reimbursement from your FSA. Claims for reimbursement of eligible expenses submitted on the appropriate forms and accompanied by acceptable documentation will be paid promptly by the Claims Administrator.

If, for example, you believe you are entitled to a greater benefit than that determined by the Claims Administrator, you may file a claim in writing with the Claims Administrator. The Claims Administrator will either allow or deny your claim, in writing, usually within 90 days, though it may extend this period for an additional 90 days if necessary. If your claim is denied, the written notice will include:

- The specific reason(s) for the denial and reference to the pertinent Plan provisions upon which the denial is based;
- A description of any additional material or information you need to perfect your claim and the reasons why such material or information is necessary; and
- An explanation of the Plan's appeal procedures.

If your claim is denied, you may appeal your claim to the District's General Manager.

Appealing a Claim — If your claim is denied, you or your authorized representative may appeal the denial to the District's General Manager, which has review authority for all District benefits matters. Your appeal must be filed in writing within 60 days after the receipt of the written notice of denial.

You may review pertinent documents and submit issues and comments in writing in support of your appeal. The District Manager's decision on appeal usually will be made within 60 days after receiving the appeal, unless special circumstances require an extension of an additional 60 days (such as to hold a hearing). The decision on review will be final and binding on participants, dependents and any other interested party.

In no event may you or your covered dependents challenge a decision of the Claims Administrator or the General Manager in court or any other administrative proceeding until these claim and appeal procedures have been concluded. No findings or decisions of the Claims Administrator or the General Manager may be overturned by such a proceeding unless the Claims Administrator or the General Manager has acted in an

arbitrary and capricious manner regarding your claim for benefits.

MISCELLANEOUS PROVISIONS

The District reserves the right to amend or terminate the Plan.

Plan Amendment and Termination

The District, in its sole discretion, reserves the right to amend, modify, suspend, withdraw or terminate the Plan in whole or in part at any time. Any such change or termination in benefits will be solely the decision of the District. Any amendment or termination of the Plan may be made effective by a written instrument executed by the District's Board of Trustees or the Board's designee.

The Plan does not alter your employment status.

No Guarantee of Employment

Neither the Plan nor this SPD constitutes a contract of employment between you and the District. Neither the establishment and maintenance of the Plan, nor anything contained in the Plan or this SPD:

- gives you the right to continue in employment with the District or to be reemployed after the termination of your employment, or
- limits any rights the District may have to discipline you or terminate your employment with the District.

Your benefits may be terminated at any time.

No Vested Right to Benefits

Your participation in the Plan does not guarantee your right to receive or to continue to receive Plan benefits in the future.

Plan benefits may not be assigned or alienated.

Protection Against Creditors

To the extent permitted by law, and except for monies owed to the District, no Plan benefit payment will be subject in any way to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void.

Summary of Material Modifications
To The
Summary Plan Description for the
Downers Grove Sanitary District Flexible Compensation Plan

This Summary of Material Modifications ("SMM") describes important changes to the Summary Plan Description ("SPD") for the Downers Grove Sanitary District Flexible Compensation Plan (the "Plan") sponsored by the Downers Grove Sanitary District (the "District"). The changes described below are effective as of January 1, 2010, and supersede any contrary provisions included in the SPD, although the remainder of the SPD remains in effect. Please keep this SMM with your SPD.

Premium Conversation Benefit	The Plan offers a Premium Conversion Benefit that allows you to pay, on a pre-tax basis, any required employee contributions for the cost of District-sponsored group health plan coverage.
You set aside before-tax dollars to pay certain expenses	When you enroll in the Plan, you can elect to participate in the Premium Conversion Benefit. If you elect this benefit, the Plan Administrator will deduct from your salary, on a pre-tax basis, your required contributions for the cost of District-sponsored group health plan coverage.
Only certain expenses are allowed on a pre-tax basis.	Under the Premium Conversation Benefit, you may only deduct from your salary the cost of group health plan coverage sponsored by the District. You may not deduct the cost for any other group health plan coverage. Only those premiums which are for coverage for either you or your eligible dependents may be deducted from your salary on a pre-tax basis.
You do not need to re-enroll in the Plan every year for the Premium Conversion Benefit	Unlike the FSA, if you are participating in the Plan and you do not re-enroll in the Premium Conversion Benefit during a subsequent annual enrollment period, the Plan Administrator will assume you wish to continue deducting from your salary, on a pre-tax basis, your group health plan premiums. The amount of your contribution will be automatically adjusted to reflect any increase or decrease in your portion of the cost. If you are not eligible to enroll in the Plan during the initial or any subsequent annual enrollment period, you may enroll within 60 calendar days after you become eligible. If you enroll during this 60-day period, your coverage under the Plan will be effective as of the date you became eligible. Otherwise, you will have to wait until the next enrollment period to begin participating.

This document is intended as a summary of material modifications with respect to the SPD. The terms and conditions of the Plan are governed by the plan document. In the event of any inconsistency between this SMM and the plan document, the plan document shall control. The District reserves the right to modify, amend, or terminate the Plan at any time, in its sole discretion.

Summary of Material Modifications
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This Summary of Material Modifications ("SMM") describes important changes to the Summary Plan Description ("SPD") for the Downers Grove Sanitary District Flexible Compensation Plan (the "Plan") sponsored by the Downers Grove Sanitary District (the "District"). The changes described below are effective as of January 1, 2013, and supersede any contrary provisions included in the SPD, although the remainder of the SPD remains in effect. Please keep this SMM with your SPD.

Change in Plan Year

Participants in the Plan are limited in the amount they may defer from income to use for qualifying medical expenses (under the Health Care Expense Reimbursement portion of the Plan) and for qualifying dependent care expenses (under the Dependent Care Expense Benefit portion of the Plan). These limits are determined based on the Plan year, which was previously the calendar year (i.e., January 1st through December 31st).

The District now desires to change the Plan year to coordinate with the policy years under the District's group medical, dental and vision insurance coverages. To do so, the Plan will initially have a short Plan year, running from January 1, 2013 through May 31, 2013. Then, each subsequent Plan year will run from June 1st through May 31st.

During the short Plan year, the amount you may defer will be limited on a pro rata basis. It is important to consider these limits when making your upcoming deferral election during open enrollment. For the period running from January 1, 2013 through May 31, 2013, your deferrals will be limited as follows:

Benefit	Maximum Deferral Amount
Health Care Expense Reimbursement	$1,170
Dependent Care Expense Benefit	$2,500 ($1, 125 for a married taxpayer filing as a single individual)

When determining how much to defer for the short Plan year, please keep in mind these limits and remember that the amounts may only be used for qualifying expenses incurred on or before May 31, 2013. (You may still submit expenses incurred prior to that date for reimbursement any time before august 15, 2013).

Beginning with the Plan year commencing June 1, 2013 and running through May 31, 2014, and for each subsequent Plan year, you will once again be permitted to defer the full amount, as described below:

Benefit	Maximum Deferral Amount
Health Care Expense Reimbursement	$2,340
Dependent Care Expense Benefit	$5,000 ($2,500 for a married taxpayer filing as a single individual)

Again, remember to carefully consider your anticipated expenses prior to electing your deferral amount. Any amount you defer in subsequent Plan years (after the short plan year) must be used for qualifying expenses incurred on or before May 31st of each year. (You may still submit expenses incurred prior to that date for reimbursement any time before the August 15th following the close of the Plan year).

This document is intended as a summary of material modifications with respect to the SPD. The terms and conditions of the Plan are governed by the plan document. In the event of any inconsistency between this SMM and the plan document, the plan document shall control. The District reserves the right to modify, amend, or terminate the Plan at any time, in its sole discretion.