LITTLETON PUBLIC SCHOOLS SECTION 125 PLAN

SUMMARY PLAN DESCRIPTION

July 1, 2012

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LITTLETON PUBLIC SCHOOLS SECTION 125 PLAN

INTRODUCTION

We have amended and restated the Littleton Public Schools Section 125 Plan (with Premium Only Plan, Health Flexible Spending Account, Dependent Care Flexible Spending Account and Health Savings Account components) (the “Plan”) that we previously established for you and other eligible employees. Under the Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this summary plan description (“SPD”). We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income taxes and PERA contributions. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income taxes or PERA contributions are withheld. This means that you will pay less tax and have more money to spend and save.

This SPD describes the Plan’s benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If there is a conflict between an insurance contract and either the Plan document or this SPD, the insurance contract will control. This SPD is also available on the Littleton Public Schools (the “District”) website under Employee Benefits—Section 125 for your convenience. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator (“Administrator”).

This SPD describes the current provisions of the Plan as amended and restated effective July 1, 2012, which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code of 1986, as amended (“Code”) and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (“IRS”) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other Plan representative). The name and address of the Administrator can be found in Section VIII of this SPD entitled "General Information About Our Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this SPD as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we

have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain enrollment forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan if you are on the payroll records of the District as a common law employee in a regular position generally working 20 hours or more per week and you have completed 30 days of employment. Of course, if you were already a Participant before this amendment and restatement, you will remain a Participant.

3. When is my entry date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an enrollment form to participate in the Plan. The enrollment form includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

If you are covered under the health, dental or vision benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or spending accounts which must be set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income tax or PERA contributions (for your pre-tax contributions other than your pre-tax Health Savings Account contributions). In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See Section VIII of this SPD entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each Plan Year, we will automatically contribute on your behalf enough of your compensation to pay for the benefit coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your

compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the Plan Year.

2. How is my compensation measured under the Plan?

Compensation under the Plan means the total cash amount that is paid to you each Plan Year.

3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit (see Section IV entitled "Benefits" for more information on the benefits available). It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

4. When must I decide which accounts I want to use?

With the exception of the Health Savings Account component, you are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

If you are already covered under the health, dental or vision benefits, you will automatically become a Participant to the extent of the premiums for such benefits unless you elect, during the election period (defined below), not to participate in the Plan.

5. When is the election period for our Plan?

Your election period will start on the date you first meet the "eligibility requirements" and end 30 days after your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. You will receive information each year about the election period or Open Enrollment period.

6. May I change my elections during the Plan Year?

Generally, with the exception of the Health Savings Account component (for which prospective election changes are generally permitted), you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections.

A. Change in Status Events: You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a "change in status":

(1) Legal Marital Status – Marriage, divorce, death of a spouse, legal separation or annulment;

(2) Number of Dependents -- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

(3) Employment Status -- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements – One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

(5) Residency – A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

There are detailed rules on when a change in election is deemed to be consistent with a change in status.

B. Special Rules for Dependent Care Flexible Spending Account:

(1) You may change or terminate your election with respect to a "change in status" event only if:

(a) such change or termination is made on account of and conforms with a "change in status" that affects eligibility for coverage under the Dependent Care Flexible Spending Account; or

(b) your election change is on account of and conforms with a "change in status" that affects the eligibility of dependent care expenses for the available tax exclusion.

(2) You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example:

(a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and

(b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

(3) You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

C. Special Rules for Premium Only Plan and Health Flexible Spending Account Changes:

There are laws that give you rights to change your Premium Only Plan and Health Flexible Spending Account elections for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

(1) Special COBRA Rules (Premium Only Plan). Regardless of the consistency requirement, if you, your spouse, or your dependent becomes eligible for continuation coverage under the District's group health plan as provided under COBRA or any similar state law, then you may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

(2) Special Enrollment Rights (Premium Only Plan). In certain circumstances, enrollment for health insurance benefits may occur outside the Open Enrollment period.

(a) Birth or adoption of a child, or change of legal custody of a child.

(b) Marriage.

(c) Your previously declined enrollment for you or your dependent(s) while other health insurance or group health insurance was in effect, and you or your dependent(s) lose eligibility for such other coverage (or the employer stops contributing toward your dependent's other coverage).

(3) Additional Special Enrollment Rights (Premium Only Plan). You may change your election under the Plan when enrollment for a group health plan occurs outside the Open Enrollment period due to one of the following special enrollment rights:

(a) coverage for you or your dependent under a Medicaid plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage and you request coverage under the group health plan not later than 60 days after the date of termination of such coverage;

(b) you or your dependent become eligible for state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan and you request coverage under the group health plan not later than 60 days after the date you or your dependent are determined to be eligible for such assistance.

When one of the foregoing special enrollment rights applies to your group health plan, you may change your election under the Plan to correspond with the special enrollment right. In order to change your election, you must inform the Administrator and complete a new salary redirection election within 60 days after the termination of Medicaid or state children's health insurance program coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

(4) Judgment, Decree or Order (Premium Only Plan and Health Flexible Spending Account). If a judgment, decree, or order from a divorce, separation, annulment or custody change requires your child (including a foster child who is your dependent) to be covered under the health, dental or vision benefits under the Premium Only Plan or the Health Flexible Spending Account component, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former spouse) cover the child, then you may change your election to revoke coverage for the child if such coverage is, in fact, provided for the child.

(5) Medicare or Medicaid Entitlement (Premium Only Plan and Health Flexible Spending Account). If you, your spouse, or your dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's health coverage under the Premium Only Plan component, and/or your Health Flexible Spending Account coverage may be canceled completely but not reduced. Similarly, if you, your spouse, or your dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's health coverage under the Premium Only Plan component, and/or your Health Flexible Spending Account, as applicable.

(6) Cost Changes (Premium Only Plan). If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely, but only if no other benefit package option provides similar coverage.

(7) Significant Curtailment of Coverage (Premium Only Plan). If the coverage under a Benefit is significantly curtailed and/or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage, or revoke your election entirely, but only if no other benefit package option provides similar coverage.

(8) Addition or Significant Improvement of Benefit Package Option (Premium Only Plan). In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan.

(9) Change of Coverage Due to Change Under Certain Other Plans (Premium Only Plan). There are certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

(10) Loss of Other Group Health Coverage (Premium Only Plan). You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

D. Rules for Health Savings Account:

You may increase, decrease, or revoke your Health Savings Account contribution election prospectively at any time during the Plan Year. Your election change will be prospectively effective on the first day of the month following the month you properly submit your election change.

No other benefit package option election changes can be made as a result of a change in your Health Savings Account election unless permitted as a result of events otherwise described above.

7. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will assume you want your elections for the Premium Only Plan only to remain the same and you will not be considered a Participant for the Health Flexible Spending Account, Dependent Care Flexible Spending Account, or Health Savings Account under the Plan for the upcoming Plan Year.

If you wish to participate in either the Health Flexible Spending Account, Dependent Care Flexible Spending Account, and/or Health Savings Account, you must complete a new enrollment form each Plan Year during the election period.

Once you have enrolled in the Premium Only Plan, your participation will continue until you complete a form during the election period to stop your participation for the next Plan Year. **If you are within four years of retirement, you may wish to stop your participation in all Plan benefits in order to maximize your PERA retirement benefits.**

IV
BENEFITS

1. What benefits are available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

A. Premium Only Plan:

(1) The Premium Only Plan allows you to use tax-free dollars to pay for certain premium expenses under various benefit programs that we offer you. These premium expenses include:

(a) Health care premiums under our insured group medical plan.

(b) Dental premiums.

(c) Vision insurance premiums.

(2) Under our Plan, we will establish sub accounts for you for each different type of benefit coverage that is available. Also, certain limits on the amount of coverage may apply.

(3) The Plan Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contract providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

(4) Any benefits to be provided by insurance will be provided only after:

(a) you have provided the Plan Administrator the necessary information to apply for insurance, and

(b) the insurance is in effect for you.

B. Health Flexible Spending Account:

The Health Flexible Spending Account enables you to pay for expenses which are not covered by our insured medical plans and saves taxes/PERA contributions at the same time. The Health Flexible Spending Account allows you to be reimbursed by the District for out-of-pocket medical, dental and/or vision expenses incurred by you and your eligible dependents. (For more details regarding eligible dependents, you can access the District website under Employee Benefits or review the new employee Benefits booklet in the section entitled “Benefit Eligibility.”) The expenses which qualify are those permitted by Code Section 213. A list of covered expenses is available from 24HourFlex, the Service Provider. A sample list is found at the end of this SPD. Expenses to purchase over-the-counter medicines or drugs that are used for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or functions of the body do not qualify, unless obtained by prescription or is insulin.

You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is $2,500. Please note that the most you can contribute for each calendar year beginning January 1, 2013 is also $2,500. This amount is indexed for inflation and may change each calendar year. In order to be reimbursed for a health care expense, you must submit to 24HourFlex, the Service Provider, an itemized bill from the health care provider. We will also provide you with a debit or credit card to use to pay for medical expenses, such as co-pays, deductibles, medical equipment and drug costs. The Service Provider will provide you with further details or you can access the District website under Employee Benefits—Section 125. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

Your Health Flexible Spending Account election may be for: General Purpose Health Flexible Spending Account coverage or Limited Purpose Flexible Spending Account (Dental/Vision Only) coverage.

Note: You cannot elect Health Savings Account benefits and Health Flexible Spending Account benefits together unless you elect the Limited Purpose Flexible Spending Account (Dental/Vision Only) Option.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you are a member of a reserve unit and are ordered or called to active duty, then you may be able to request a Qualified Reservist Distribution ("QRD") from your Health Flexible Spending Account. A QRD is a distribution of amounts from your Health Flexible Spending Account that is not dependent on whether you have incurred eligible medical expenses. You can only request this distribution if you are ordered or called to active duty for a period in excess of 180 days or for an indefinite period. You may only request this distribution during the period beginning on the date of the order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the order or call.

You can only receive one QRD during any Plan Year.

Note that, unlike a reimbursed expense under the Health Flexible Spending Account, a QRD will be subject to income taxes when distributed.

The most you can receive is the amount you have actually contributed minus any reimbursements you have already received (or that are being processed for reimbursement).

Any claims that you incur or submit after the date of the payment of your QRD will not be processed. You will not be entitled to any additional reimbursements for the Plan Year in which the QRD is made.

C. Dependent Care Flexible Spending Account:

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the Dependent Care Flexible Spending Account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the Dependent Care Flexible Spending Account.

An eligible dependent includes any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Flexible Expenses." (For more details regarding eligible dependents, you can access the District website under Employee Benefits or review the new employee Benefits booklet in the section entitled "Benefit Eligibility.")

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. We will also provide you with a debit or credit card to use to pay for dependent care expenses. The Service Provider will provide you with further details or you can access the District website under Employee Benefits—Section 125. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of:

(1) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns);

(2) your taxable compensation; or

(3) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). Also, in order to have the reimbursements made to you from this Dependent Care Flexible Spending Account be excludable from your income, you must provide a statement from the dependent care provider including the name, address, and in most cases, the taxpayer identification number of the dependent care provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a dependent care tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. For more information about how the dependent care tax credit works, see IRS Publication No. 503 (“Child and Dependent Care Flexible Expenses”).

You may also wish to consult a tax advisor.

D. Health Savings Account:

The Health Savings Account (“HSA”) enables you to make pre-tax contributions to an HSA established and maintained outside of the Plan with an HSA trustee/custodian. Benefits provided under the HSA, which consist of the ability to contribute to the HSA on a pre-tax salary redirection basis in addition to any District contributions are called HSA Benefits.

To participate in the HSA Benefits, you must be an “HSA-Eligible individual”. This means that you are eligible to contribute to an HSA under the requirements of Code Section 223 and that you have elected qualifying High Deductible Health Plan coverage and have not elected any disqualifying non-High Deductible Health Plan coverage. The High Deductible Health Plan offered by the District that is intended to qualify is the CIGNA Open Access Plus – In Network CDHP/HSA. You must also not have any disqualifying coverage—such as coverage under a spouse’s plan, including spouse’s health flexible spending account. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”). In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian. The District has selected Chase Bank as the HSA trustee/custodian to receive pre-tax salary redirection contributions. You must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax salary reduction contributions.

If you elect Health Flexible Spending Account benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the Limited Purpose Flexible Spending Account (Dental/Vision Only) Option.

In the event that an expense is eligible for reimbursement under both the Limited Purpose Flexible Spending Account and the HSA, you may seek reimbursement from either the Limited Purpose Flexible Spending Account or the HSA, but not both.

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made ($3,100 for single coverage and $6,250 for family coverage for calendar year 2012; $3,250 for single coverage and $6,450 for family coverage for calendar year 2013. This amount is indexed for inflation). An additional catch-up contribution of $1,000 may be made if you are age 55 or older (you must certify your age to the District).

In addition, the maximum annual contribution is:

(a) reduced by any matching (or other) District contribution made on your behalf; and

(b) pro-rated for the number of months in which you are an HSA-Eligible Individual.

The District may make a contribution to your HSA subject to Board of Education approval in addition to your pre-tax salary redirection contributions.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred from your Health Flexible Spending Account and/or Dependent Care Flexible Spending Account and/or Health Savings Account. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Acceptable forms for submitting these requests for reimbursement to 24HourFlex, the Service Provider, are available on the District intranet under Human Resources—Benefits. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to PERA contributions. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in your Dependent Care Flexible Spending Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

With the exception of the Health Savings Account, any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for

which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide to which benefits you want to contribute and how much to place in each Account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each Account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take a leave under the Family and Medical Leave Act, you may continue or stop your existing elections for health insurance, HSA Benefits and the Health Flexible Spending Account. If you stop your enrollment in these benefits or coverage terminates due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue or stop your enrollment and resume it when you return. You can resume your coverage at its original level and make payments for the time that you were on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Unless you complete an enrollment form to resume coverage at that level, your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, or you may pay for your coverage on an after-tax basis while you are on leave.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. These rights can include extended health care coverage. If you may be affected by this law, ask your Plan Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

A. You will remain covered by insured or self-insured benefits, but only for the period for which premiums have been paid prior to your termination of employment. You may also have COBRA rights.

B. You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Flexible Spending Account at the time of termination of employment. However, no further

salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

C. You may elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year.

D. If you elect to continue your participation in the Health Flexible Spending Account, you must continue to make any required contributions to the Plan on an after tax/PERA basis.

E. If you elect not to continue participation in the Health Flexible Spending Account, participation will cease and no further salary redirection contributions will be contributed on your behalf. You will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

F. If your participation in the Health Flexible Spending Account ceases, you (or your beneficiaries) will be able to submit claims for health care expenses incurred prior to your date of termination.

You, your spouse and your dependents will generally be covered together for Health Flexible Spending Account coverage. You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount to provide this benefit. When you terminate employment the Plan Administrator will provide you with a notice regarding your right to continue coverage.

G. For information about obtaining distributions from your HSA at any time, including your termination of employment, contact the trustee/custodian of your HSA established and maintained outside the Plan.

6. Qualified Reservist Distributions Under the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act")

The HEART Act allows active Participants in the Health Flexible Spending Account who are called to duty the option to receive a one-time distribution of their Health Flexible Spending Account balance so they will not forfeit these dollars unnecessarily.

In order to be eligible for a partial or total "qualified reservist distribution" under the HEART Act, the following is required:

(a) the reservist must be an active Participant in the Health Flexible Spending Account;

(b) the reservist must be called to duty for at least 180 days (or for an indefinite period);

(c) the reservist must provide a copy of the order to duty to the District and request the one-time distribution from his/her Health Flexible Spending Account balance on or before the last day of the Plan Year;

(d) distributions are available from the Health Flexible Spending Account balance only;

(e) the distribution amount will be calculated as follows: Health Flexible Spending Account balance contributions to date minus eligible reimbursements to date; and

(f) the HEART Act distribution will be made within a reasonable period of time and is taxable as ordinary income: subject to any Federal, State, Medicare or local taxes.

7. Will my PERA benefits be affected if I participate in the Section 125 Plan?

Yes, because PERA retirement benefits are based on the four highest 12 month periods of earnings, you may wish to drop out of the Plan during those periods in order to maximize your PERA retirement benefits. You may drop out of the Plan for this reason only during Open Enrollment by completing the appropriate form available from the District Benefits Office.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers or highly paid.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

24HourFlex, the Service Provider, will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular spending account by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Littleton Public Schools Section 125 Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended and restated Plan are effective on July 1, 2012. Your Plan was originally effective on January 1, 1988.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on July 1 and ends on June 30.

2. Employer Information

Your Employer's name, address, and identification number are:

Littleton Public Schools
5776 S. Crocker Street
Littleton, Colorado 80120
84-6000862

3. Plan Administrator Information

The name, address and business telephone number of your Plan Administrator are:

Littleton Public Schools
5776 S. Crocker Street
Littleton, Colorado 80120
303-347-3366

The Administrator is responsible for the administration of the Plan. The Administrator and the Service Provider identified below will answer questions you may have about our Plan. You may contact the Administrator or the Service Provider for further information about the Plan.

4. Service Provider/Claims Submission

The Service Provider for the submission of claims is responsible for the adjudication and the processing of all Plan reimbursements. The Service Provider also maintains the records for the Plan. Plan participants can contact 24HourFlex directly with any claims questions. Claims for expenses should be submitted to:

24HourFlex
2851 S. Parker Road, #230
Aurora, CO 80014

Phone: 303-369-7886
Toll free: 800-651-4855
Fax: 303-369-0003

5. Service Provider/HSA Trustee/Custodian

Chase Bank

6. Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Littleton Public Schools
5776 S. Crocker Street
Littleton, Colorado 80120

7. Type of Administration

The type of Administration is Employer Administration.

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

You should submit all reimbursement claims during the Plan Year, **but in any event, no later than 90 days after the end of a Plan Year**. Any claims submitted after that time will not be considered.

Claims for benefits that are insured will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to 24HourFlex, the Service Provider. If a spending account reimbursement claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If the Service Provider fails to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

X
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. The Littleton Public Schools Section 125 Plan will help you keep more of the money you earn by lowering the amount of taxes and PERA contributions (for your pre-tax contributions other than your pre-tax Health Savings Account contributions) you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.