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Comments: Cafeteria Plan
Summary Plan Description for Web Site.
for EE's.

SUMMARY PLAN DESCRIPTION
Town of Windham CAFETERIA PLAN

AMENDED FOR THE PLAN YEAR COMMENCING JANUARY 1, 2009

PLAN NO. 501

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SUMMARY PLAN DESCRIPTION

TOWN OF WINDHAM CAFETERIA PLAN

PART I UNDERSTANDING YOUR BENEFITS

This booklet is a summary of the Cafeteria Plan (the "Plan") that the employer named in Part IV ("Employer") has established for you and other eligible employees. The summary is currently being amended for the Plan Year commencing January 1, 2009 and describes your benefits and discloses your portion of the costs, if any. Read this booklet carefully, share it with your family, and keep it handy for future reference.

Please note that this summary does not attempt to cover all details. Further details are contained in the official Plan document. In the event there is a conflict between this summary plan description and the comprehensive Plan document, the Plan document will control. You (or your beneficiary in the event of your death) are entitled to examine, without charge, all plan documents and any other documents or reports maintained by each plan in which you are a participant.

PART II ELIGIBILITY AND BENEFITS

What The Plan Offers

The Cafeteria Plan gives you the choice of receiving part of your pay in the form of benefits instead of cash. The benefits include the following:

Health Insurance, Dental Insurance, Medical Reimbursement Plan (Effective February 1, 2009), Dependent Care Reimbursement Plan (Effective February 1, 2009)

These benefits are provided by separate benefit plans sponsored by the Employer. Detailed information about them may be found in the summary plan description for each plan.

When You Are Eligible

As a rule, you are eligible to participate in the Plan for as long as you meet the following requirements:

Employees hired to work a minimum of 30 hours per week on an annual basis are eligible to participate in the Plan the 1st day of the first full month after meeting the 30-day waiting period.

In general, your participation in this Plan will end when you no longer meet these eligibility requirements. However, you may be able to continue some of your elected benefits under the separate benefit plans for a period of time if:

- you are absent from work due to an authorized leave under the Family and Medical Leave Act (FMLA);
- you enter qualifying military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA); or
- you have health care continuation of coverage rights under COBRA.

More information about continuing your benefits under these laws may be found in the summary plan descriptions for the separate benefit plans. You may also ask the Plan Administrator for further details.

How You Can Participate

To participate, you must return a properly completed Benefit Election form to the Plan Administrator within the appropriate time period. In addition, you may be required to complete individual carrier applications or other forms for the medical benefit option you elect. The time periods work like this:

The time periods work like this:

- If you are eligible to participate on the first day of a Plan Year (identified in Part IV below), either as a new participant or a continuing participant, you will have the opportunity to make a Benefit Election during the open enrollment period that precedes each new Plan Year. The Plan Administrator will inform eligible employees about each open enrollment period. The Plan Administrator must receive your Benefit Election form by the end of the open enrollment period, and your election will take effect at the beginning of the Plan Year.
- If you first become eligible after the first day of a Plan Year, the Plan Administrator must receive your Benefit Election form within 30 days after you first become eligible. If your election is received later in the month (but within your election period), your participation will begin with the first day of the second following month. Note that if you do not enroll within 30 days of becoming eligible, you must wait for the next open enrollment period to begin participation in the Plan, unless you are permitted to make a Benefit Election change as explained below.

The following rules apply if you terminate and then return to eligible employment:

- (a) If you terminate and return within a 30-day period during the same Plan Year, generally you may re-commence participation only by reinstating the same Benefit Election as was in effect when you terminated employment.
- (b) To the extent that you have protected benefit rights under applicable laws such as FMLA or USERRA, then you will not be required to satisfy any waiting period under the Plan and you may re-commence participation immediately.

Your Choice Of Benefits

You indicate your choice of benefits for each Plan Year on the Benefit Election form. As explained above, these benefits are offered through separate benefit plans sponsored by the Employer. The Benefit Election form indicates your agreement to have your Employer reduce your wages or salary, and use the amount of the reduction to pay your contributions to the benefit plans on a pre-tax basis. Your selection of benefits is subject to adjustment or restriction by the Plan Administrator to ensure compliance with the Internal Revenue Code or other applicable laws. Any such adjustments or restrictions will be made on a uniform and nondiscriminatory basis.

Changing Your Benefit Election During a Plan Year

As a rule, your Benefit Election and elected medical benefits must remain in effect for the entire Plan Year. You may change your choice of benefits during the year only if any of the following status changes occurs:

- you (and/or your spouse or dependent) are permitted to make a special enrollment in a medical or health care plan.
- you become married or divorced, your spouse or any of your children dies, you have or adopt a child, or an individual first satisfies or ceases to satisfy the requirements for coverage as a dependent under a benefit plan;
- you (or your spouse or dependent) terminate or begin employment, experience a strike or lockout, begin or return from an unpaid leave of absence (including a Family and Medical Leave), or have another employment status change that affects your (or your spouse's or dependent's) eligibility under an employer cafeteria or benefits plan;
- you or your spouse or dependent have a change in place of residence or worksite;
- there is a judgment, decree or order in a domestic relations proceeding, including a "qualified medical child support order" (described in Part IV below), requiring you or your former spouse to provide health coverage for your child;
- you (or your spouse or dependent) become entitled to or lose coverage under Medicare or Medicaid or become eligible for COBRA coverage under the Medical Plan;

- there is a significant change in cost or coverage under a benefit plan, or a health coverage option under a benefit plan, of your (or your spouse's or dependent's) employer, or you (or your spouse or dependent) lose group health coverage sponsored by a governmental or educational institution;

Under federal law, some of these events will only permit you to change your choice of certain medical or health care benefits. In addition, any benefit change triggered by a status change must be consistent with the change in status. For example, a change to your medical coverage will be consistent with a status change only if (1) the status change results in you, your spouse or dependent gaining or losing eligibility for medical coverage, and (2) the benefit change corresponds with that gain or loss of coverage. Because the status change rules for the Plan under federal law are complex, you should contact the Plan Administrator as soon as you think you are or may become eligible for a Benefit Election change during a Plan Year.

Special Enrollment Periods

Special enrollment periods for you and your dependents apply to group medical or health care coverage made available through this Plan, in two circumstances. First, a special enrollment period applies if you (or your dependent) are eligible to enroll for medical coverage, but do not enroll because you (or your dependent) have other coverage, and then lose the other coverage. You will be offered the opportunity to enroll (and/or to enroll your dependent) without having to wait until the next open enrollment period, provided you (or your dependent) would otherwise be eligible for coverage and:

- (a) the other coverage was under COBRA, and is lost due to the exhaustion of COBRA coverage benefits; or
- (b) the other coverage was not under COBRA, and is lost due to a loss of eligibility for coverage (including a loss resulting from a legal separation, divorce, death, termination of employment, or reduction in number of hours of employment); or
- (c) the employer contributions towards the other coverage are terminated.

You and your dependents are not required to elect and exhaust COBRA coverage under another plan to enroll during a special enrollment period. If you or your dependents do elect COBRA coverage under another plan, however, the COBRA coverage must be exhausted to create a special enrollment period under this Plan. The special enrollment rights do not apply if the other coverage is lost because you or your dependent failed to pay COBRA premiums.

Second, a special enrollment period will apply if you acquire a dependent by marriage, birth, adoption, or placement for adoption. In the event you acquire a spouse, you may be added as well if you are not already enrolled for medical coverage. In the event you acquire a dependent by birth, adoption, or placement for adoption, you and/or your spouse may be added as well if you or your spouse are not already enrolled for medical coverage.

You must apply for a special enrollment in writing in the same manner as you apply to change your benefits for any other status change.

Who Pays For Your Benefits

By making your Benefit Election, you direct the Employer to apply a portion of your pay to provide benefits to you. Under current federal law the portion of your pay used to obtain benefits is not considered taxable income. Thus, if you direct your Employer to use some of your pay to provide benefits, the Employer will withhold from each of your paychecks amounts that would otherwise be payable to you as taxable compensation. By reducing your taxable income, you reduce the amount of federal and state income taxes and FICA/Social Security taxes you pay and at the same time increase your benefits. Please note that, as a result, there may be a small reduction in your Social Security retirement benefit. The reduction in the Social Security benefit generally is more than offset by your current tax savings.

If you fail to pay your required contributions for the benefits you have elected, your coverage for those benefits will terminate. When your Plan participation ends for failure to pay required contributions, you will not be able to re-commence participation in the Plan until the following Plan Year (if you are then an eligible employee).

PART III CLAIMS PROCEDURES AND YOUR LEGAL RIGHTS

Claiming Your Benefits

To apply for benefits that you have elected under the Plan, you should follow the benefit claim procedures described in the separate summary plan description for the plan providing the particular benefits. The Plan Administrator

can assist you in obtaining and completing any required forms. Any claim relating to eligibility or participation in the Cafeteria Plan itself, however, should be directed to the Plan Administrator.

If your claim under this Plan is denied, either in whole or in part, you will receive a written notice providing:

- (1) the specific reason or reasons for the denial;
- (2) specific reference to the plan provisions on which the denial is based;
- (3) the additional information, if any, needed to approve your claim and an explanation why such information is necessary; and
- (4) the plan claims review procedure.

The notice will be furnished to you within 90 days after receiving your claim. However, if special circumstances require more time for processing your claim, you will be notified before the initial 90 days are up. The notice will explain why an extension is necessary and the date a decision is expected. In no event will an extension go beyond 90 days after the end of the initial 90 days.

You may request review of a denied claim. Your request must be in writing and must be delivered to the Plan Administrator within 60 days after you receive notice of the denial. As part of the review, you or your authorized representative may examine plan documents and submit issues and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review, unless an extension of time for review is necessary. If an extension is necessary, you will be notified in writing within 60 days after the request for review is received, and a decision will be rendered as soon as possible, but not later than 120 days after the request for review is received. The notice of the decision shall include the specific reasons on which it is based and specific references to the pertinent plan provisions. If your claim is denied on review, you may file suit in a state or federal court.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Information About Claims For Medical Benefits And Disability Benefits: Please note that under federal law certain specific procedures and rules apply to any medical or health care benefits and disability benefits that may be made available under this Cafeteria Plan. Accordingly, you should be sure to consult the separate summary plan description for the applicable benefit plan. In addition, you have the right, if you appeal a claim that is denied in whole or in part, to request access to and copies of documents, records and other information that was submitted, considered or produced by the Plan Administrator in deciding your claim. You may also request access to and copies of information showing compliance with the Plan's claims procedures. Copies of any such information will be provided to you free of charge.

Your Legal Rights

As a participant in benefit plans that are made available through the Cafeteria Plan and covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), you are entitled to certain rights and protections under those plans. (The Cafeteria Plan itself is not covered by ERISA.) ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites and union halls) all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary.

Continue Group Health Plan Coverage under group medical or health care plans. Please consult the explanation of your legal rights in the separate summary plan description for the applicable benefit plan.

Continue Group Health Plan Coverage:

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under a group medical or health care plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the explanation of your legal rights in the separate summary plan description for the applicable benefit plan regarding the rules governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries:

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

Enforce Your Rights:

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

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

Assistance With Your Questions:

If you have any questions about a benefit plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PART IV OTHER THINGS YOU SHOULD KNOW

Qualified Medical Child Support Orders

If the Plan Administrator receives a qualified medical child support order, or a National Medical Support Notice, the benefit plan named in the order will provide the medical child support or health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order or notice to the extent required by law. "Alternate recipients" include any child of the participant who under a qualified medical child support order has a right to enrollment in a group health plan with respect to the participant.

A "qualified medical child support order" is a legal judgment, decree or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided). A "National Medical Support Notice" is a legal document that is similar to a qualified medical child support order.

Before providing any coverage to an alternate recipient, the plan administrator of the group health plan(s) named in the order must determine whether the medical child support order is qualified. If the plan administrator receives a medical child support order relating to you, it will notify you in writing. As soon as feasible thereafter, the Plan Administrator will inform you of its determination of whether or not the order or Notice is "qualified."

The determination that an order or Notice is qualified may affect your Benefit Election made through this Plan, and is an event that permits a change in your Benefit Election during a Plan Year. See Part II above for more information.

A participant or beneficiary in the group health plans made available through this Plan may obtain a copy of the procedures for determining the qualified status of a medical child support order or Notice without charge from the appropriate plan administrator.

How Long The Plan Lasts

Your Employer expects to continue the Plan indefinitely, but it reserves the right to terminate or amend the Plan at will, with or without notice, at any time. If the Plan is terminated, you will not be entitled to Plan benefits for periods after such termination. You will, however, continue to be entitled to benefits, in accordance with the terms of the Plan, for periods prior to the termination. Contributions to separate benefit plans, however, cease as of the date that the termination occurs.

When The Plan Year Ends

The date of the end of the year for purposes of maintaining each of the plan's fiscal records and determining the period of coverage under a Benefit Election is **December 31st**.

Who Administers The Plan

The Plan Administrator's name, address and telephone number is:

Town of Windham
Finance Director
8 School Road
Windham, ME 04062

Tele: 207-892-1907

Type Of Administration

The Plan is administered by the Plan Administrator named above. Benefits available through the Plan are administered by the persons or organizations named in the separate summary plan descriptions for those plans.

Identifying Your Employer

The name, business address and telephone number of each employer participating in the Plan are given below. Also, the nine-digit number is the employer identification number (EIN) assigned by the Internal Revenue Service:

Town of Windham
Finance Director
8 School Road
Windham, ME 04062

Tele: 207-892-1907

EIN: 01-6000440

Official Plan Name And Plan Number

The official name of the Plan described in this summary and the plan number (PN) assigned to it for identification purposes appear below:

Town of Windham Cafeteria Plan

PN: # 501

Agent For Service Of Legal Process

The agent for service of legal process for the Plan is the Plan Administrator at the address listed above.

Employment

Participation in the Plan does not give any individual the right to be retained in the employ of an employer or any other right not specified in the Plan.

Date of Summary Plan Description

This summary plan description describes the Cafeteria Plan as of January 1, 2009 forward.