Section 125 Cafeteria Plan
Summary Plan Description

Schertz-Cibolo-Universal City Independent School District

1060 Elbel Rd.
Schertz, TX 78154
Phone # (800) 880-2776
EIN 74-6029384
Plan # 501

Plan Year: September 1, 2015 – August 31, 2016

Plan Administrator: National Plan Administrators, Inc.
1101 Capital of Texas Highway South, Building E ■ Austin, Texas 78746 ■ (800) 880-2776

SUMMARY PLAN DESCRIPTION

WHAT IS A SECTION 125 FLEXIBLE BENEFIT PLAN?

A Section 125 Flexible Benefit Plan (Cafeteria Plan) is an employee benefit Plan established by your employer. The Plan is allowed under the regulations of Section 125 of the Internal Revenue Code. The Plan offers you a choice between two or more benefits. You can choose from the list of benefits that meet your specific needs.

The payments you make for the qualified benefits you have chosen can be deducted from your paycheck under a salary reduction agreement. In effect it reduces your taxable income as reported to the IRS. Simply stated, your salary deductions under the Cafeteria Plan will never be taxed. By reducing your taxable income, you are paying for the benefits you have chosen with "pre-tax" dollars. Your employer has established this Cafeteria Plan to help you *reduce your taxes* and *increase your take-home pay*.

- **WHAT SPECIAL RULES SHOULD YOU BE AWARE OF REGARDING THE PLAN?**

There are two very important issues to keep in mind:

1. Although all benefit selections are entirely voluntary (you may pick and choose), each employee is required to sign a Section 125 Benefit Election Form, even if you select no benefits or wish to keep your current benefits the same at renewal.
2. Any "pre-tax" elections will remain in effect and cannot be revoked or changed during the Plan Year unless you have one of the following changes in family status: **1)** marriage, **2)** divorce, **3)** births, **4)** adoptions, **5)** death of a dependent child or spouse, **6)** change in employment status for you, your spouse or dependents effecting eligibility requirements, **7)** change in eligibility status of a dependent, or **8)** there is a significant change in the cost of your insurance (not applicable with Flexible Spending Accounts).

   Any change in benefit election must be consistent with the change in family status that has occurred. Also, documentation of the event must be given to your Benefits Department within 30 days of the change in family status, and a Section 125 Revocation/Change Form must be completed.

- **WHO CAN PARTICIPATE IN THE PLAN?**

An Employee is eligible to participate in this Plan if the Employee satisfies the conditions for coverage under the Group Insurance. Once the Employee has met the eligibility requirements and has completed their probationary period upon hire.

- **WHEN MUST YOU ENROLL?**

Open Enrollment period shall be 31 days prior to the Plan Year start date. Employees may elect to participate and select benefits each Plan Year during Open Enrollment. Benefits selected cannot be changed unless there has been an allowable change (i.e. change in family status). An Election form shall be due and returnable to the Administrator on or before the last day of the Open Enrollment Period. If an eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period.

- **WHAT BENEFITS ARE AVAILABLE UNDER THE PLAN?**

Typical benefits that may be deducted under the Cafeteria Plan include:

Pre-Tax Qualified Benefits

Insurance Programs:

- Medical Premiums
- Dental and Vision Premiums
- Group Term Life Insurance up to $50,000
- Cancer & Specified Disease Plans Premiums
- Heart/Stroke Premiums

Flexible Spending Accounts:

Medical Expense Reimbursement Accounts
Orthodontia Expense Reimbursement Accounts
Dependent Care Reimbursement Accounts

The maximum allowed salary reduction for employee benefits is 50% of your gross compensation.

- **WHEN DO YOU BECOME INELIGIBLE TO CONTINUE THE PLAN?**

Participation in the Plan ceases upon death, of employment, failure to meet eligibility requirements, termination of the Plan, retirement, or failure to pay contributions required during any period in which you are on a leave of absence.

Upon termination, a participant will have 60 days after their termination date to submit claims against their remaining balance for expenses incurred prior to their termination date.

A former Participant will become a Participant again if and when he or she meets the eligibility requirements or returns from leave under the Family and Medical Leave Act (FMLA). Except as provided in the FMLA, an employee who revokes a portion or all coverage under the Plan, and returns to active employment within the same Plan Year, will not be permitted to participate again until the next Plan Year.

- **WHO IS THE ADMINISTRATOR OF THE PLAN?**

National Plan Administrators, Inc. is the Administrator for the Section 125 Flexible Benefit Plan. Any legal correspondence for the Plan should be sent to:

National Plan Administrators, Inc., P.O. Box 161630, Austin, TX 78716, (800) 880-2776.

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THIS SUMMARY PLAN DESCRIPTION IS INTENDED TO PROVIDE ONLY A GENERAL OVERVIEW OF THE PLAN'S BENEFITS AND THE RULES GOVERNING THE PLAN. YOU MUST CONSULT THE PLAN ADMINISTRATOR AND/OR PLAN DOCUMENT FOR CONTROLLING AUTHORITY.

HOW TO ACHIEVE SAVINGS THROUGH THE SECTION 125 CAFETERIA PLAN

The following example illustrates the advantage of participating in the Section 125 Cafeteria Plan as compared to participating in a plan without such benefits. Out-of-pocket costs for medical, dental and/or vision care, dependent day care expenses, or premiums that you pay for under the plan are paid for on a pre-tax basis, which ultimately saves you ***$$$!***

Without a Section 125 Plan		**With a Section 125 Plan**	
Gross Earnings	$2,000	Gross Earnings	$2,000
--Nontaxable Benefits	0	--Nontaxable Benefits	- 400
Taxable Earnings*	2,000	Taxable Earnings*	1,600
Withholding Taxes**	- 500	Withholding Taxes**	- 400
--Group Health Premiums	- 150	--Group Health Premiums	- 0
--Health Care Expenses	- 50	--Health Care Expenses	- 0
--Dependent Care Expenses	- 200	--Dependent Care Expenses	- 0
Net Spendable Income	**$1,100**	**Net Spendable Income**	**$1,200**

This example illustrates a Section 125 Plan Tax Savings of $100

** Participation in the Plan may affect future Social Security Benefits*
***Assumes a 25% marginal tax bracket*

Medical Expense Reimbursement
Flexible Spending Account (FSA)

Your employer may provide this benefit option to allow participants to save tax dollars on their eligible out-of-pocket health care expenses. The health care expenses can be for you, your spouse or any eligible dependent (those listed on your tax return).

The money you contribute to the Medical Expense Reimbursement account, through payroll deduction, is deposited into your account on a pre-tax basis. This money is deducted before taxes are calculated, which lowers your taxable income and reduces your total tax bill.

- **WHAT IS THE ADVANTAGE?**

  You can save taxes. For example: If you and your family spend $2000 annually on health care expenses, you could save the taxes on $2000 of your income. If you were in the 28% tax bracket, your savings would be approximately $560.

- **WHAT IS THE DISADVANTAGE?**

  You must estimate your total annual out-of-pocket health care expenses for the entire Plan Year. You are not allowed to make any changes during the Plan Year unless there has been a change in your family status (i.e. marriage, divorce, birth, death, adoption, or change in job status for you or your spouse). **Any change must be consistent with, and justified by, the change in your family status.**

- **HOW CAN I ESTIMATE MY EXPENSES FOR THE ENTIRE YEAR?**

  Review what you spent during the last year. If it was not an unusual year, you will probably spend approximately the same this next year. Review the examples of qualified expenses. Use the Planning Worksheet on the following page. Only expenses that are incurred during the plan year may be reimbursed under your Medical Expense Reimbursement Account. ***It is important that you budget carefully and conservatively. The maximum annual amount for contributions into a Medical Expense Reimbursement Account is $2,550; Orthodontia Expense Reimbursement is $3,000.***

- **WHAT HAPPENS IF I OVER ESTIMATE AND CAN'T CLAIM ALL THE MONEY IN THE ACCOUNT?**

  You will lose the money. The same law that allows you to participate in this plan also requires that you forfeit any unused money left in your account. This is the **"USE IT OR LOSE IT"** provision of the IRS code. Any amount left in your account, unclaimed after the grace period, at the end of a Plan Year or at your termination, will be forfeited. Even if you do not use all of the money in your account, you still may benefit from your tax savings.

- **HOW DOES THE PLAN WORK?**

  You must estimate your expenses for the entire Plan Year and agree to have your salary reduced by that amount on a monthly basis. The money is deposited in a Flexible Spending Account at NPA.

  After you have incurred an expense, you must submit a claim form, and attach your original itemized receipts or bills as evidence of your qualified health care expense. You may file claims at any time during the Plan Year; however, the Administrator must receive claims prior to noon on the processing date of every month. A reimbursement check or direct deposit will be issued to you. Claims received after the claim filing deadline will be processed during the following claims payment cycle.

  You will have a run-out period at the end of the Plan year to file receipts for reimbursement of expenses incurred during the just completed Plan Year, or incurred prior to your termination. If you terminate your employment prior to the end of the Plan Year, you may be eligible to continue the Medical Reimbursement Account on an after-tax basis through COBRA continuation of coverage.

- **Examples of <u>QUALIFIED EXPENSES:</u>**
  Expenses must be <u>Medically Necessary</u>.
  Medical Co-Pays and Deductibles
  Dental Expenses and Orthodontia Contracts
  Eye exams, Eyeglasses, and Contact Lenses
  Eligible Prescription Drugs
  Hearing Exams, Aids, and Batteries
  Chiropractors – medical care only
  Psychiatrists and Psychologists

- **Examples of <u>NON-QUALIFIED EXPENSES:</u>**
  Expenses reimbursed by an insurance company
  Cosmetic Surgery/Procedures
  Teeth Whitening
  Dancing or Swimming Lessons, Vacations
  Expenses not incurred during the Plan Year
  Marriage Counseling
  Vitamins
  Prescription Drugs/Programs for Hair Growth
  Over-the-Counter items that are merely beneficial to the general health

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PLANNING WORKSHEET

FOR

MEDICAL EXPENSE REIMBURSEMENT ACCOUNT

Planned Vision Care

Examinations	$_____
Corrective Lenses	$_____
Contact Lenses, Solutions, Materials	$_____
Other	$_____

Planned Dental Care

Routine Cleaning and Examinations	$_____
Fillings	$_____
Crowns and Root Canals	$_____
Dentures, Bridgework	$_____
Oral Surgery	$_____
Orthodontic Down Payments	$_____
Orthodontic Monthly Payments	$_____
Other	$_____

Planned Medical Care

Physicals, Well Care Examinations	$_____
Office Visit Co-pays or Costs	$_____
Prescription Co-pays or Costs	$_____
Immunizations	$_____
Surgery	$_____
Medical Supplies and Equipment	$_____
Hearing Aids	$_____
Obstetrical and Delivery	$_____
Well Child Care	$_____
X-ray and Laboratory	$_____
Chiropractor/ Physical Therapy	$_____
Over the Counter medications (used to treat Or cure an illness)	$_____
Other	$_____
TOTAL ANNUAL ESTIMATED EXPENSES FOR MEDICAL CARE REIMBURSEMENT	**$**_____

PLEASE NOTE:
<u>REGULATIONS REQUIRE THAT YOUR EXPENSE MUST HAVE BEEN INCURRED DURING THE PLAN YEAR.</u>
EXPENSES ARE INCURRED WHEN YOU RECEIVE THE CARE, NOT WHEN YOU ARE FORMALLY BILLED OR WHEN YOU PAY THE BILL.

Orthodontia Expense Reimbursement
Flexible Spending Account (FSA)

Your employer may provide this benefit option to allow participants to save tax dollars on their eligible out-of-pocket Orthodontia expenses. These expenses can be for you, your spouse, or any eligible dependent (those listed on your tax return).

The money you contribute to the Orthodontia Expense Reimbursement Account, through payroll deduction, is deposited into your account on a pre-tax basis. This money is deducted before taxes are calculated, which lowers your taxable income and reduces your total tax bill.

- **WHAT IS THE ADVANTAGE?**

  You can save taxes. For example: If you and your family spend $2000 annually on **Orthodontia** expenses, you could save the taxes on $2000 of your income. If you were in the 28% tax bracket, your savings would be approximately $560.

- **WHAT IS THE DISADVANTAGE?**

  You must estimate your total annual out-of-pocket **Orthodontia** expenses for the entire Plan Year. You are not allowed to make any changes during the Plan Year unless there has been a change in you family status (i.e. marriage, divorce, birth, death, adoption, or change in job status for you or your spouse). **Any change must be consistent with, and justified by, the change in your family status.**

- **HOW CAN I ESTIMATE MY EXPENSES FOR THE ENTIRE PLAN YEAR?**

  Only **Orthodontia** expenses that are incurred during the plan year may be reimbursed under your **Orthodontia** Expense Reimbursement Account. Theses expenses include the Down Payment and Monthly Payments according to your **Orthodontia Contract** with your orthodontist.

  ***It is important that you budget carefully and conservatively*.** The same law that allows you to participate in this plan also mandates that you forfeit any unused money left in your account. This is the "**USE IT OR LOSE IT**" provision of the IRS Code. Any amount left in your account unclaimed after the run-out period, at the end of a Plan Year, or at your termination, will be forfeited. Even if you do not use all of the money in your account, you may still benefit from your tax savings.

  The maximum annual contributions into an Orthodontia Expense Reimbursement Account are $3,000.

- **HOW DOES THE PLAN WORK?**

  The monthly contribution amount is deposited in a Flexible Spending Account at NPA. After you have incurred an **Initial Orthodontia Deposit** amount or the **Monthly Orthodontia Payment**, you may submit a claim form **along with the copy of your Orthodontia Contract and an itemized receipt as evidence of your expense**.

  The actual reimbursement of orthodontia expenses will not exceed the year-to-date amount credited to your Orthodontia Expense Account, less any prior reimbursements.

  You may file claims at any time during the Plan Year. Claims not received prior to the claim filing deadline will be processed during the following claim payment cycle. A reimbursement check or direct deposit (if available) will be issued to you. The orthodontia reimbursement check will be for qualified expenses claimed up to the amount, which is available in your account. You will have a run-out period at the end of the Plan Year to file receipts for reimbursement of expenses incurred during the just completed Plan Year, or incurred prior to your termination.

Dependent/Child Care Reimbursement
Flexible Spending Account (FSA)

Your employer may provide this benefit option to allow participants to save tax dollars on Dependent/Child Care expenses incurred while you work. The IRS does not allow you to claim the Federal Child Care Credit and tax shelter your dependent/child care cost in the Employer's Flexible Benefit Plan. Each person must evaluate which program will best fit his or her needs, and save the most taxes.

The money you contribute to the Dependent/Child Care Reimbursement Account, through payroll deduction, is deposited into your account on a pre-tax basis. This money is deducted before taxes are calculated, which lowers your taxable income and reduces your total tax bill.

- **WHAT IS THE ADVANTAGE?**

  You can save taxes. The money that you set aside in your account is not subject to federal taxes. If your child care is $5000 per year and you are in the 28% tax bracket, **you could save $1400 in taxes.**

- **WHAT IS THE DISADVANTAGE?**

  You must estimate your total annual dependent/child care expenses for the entire Plan Year. You are not allowed to make any changes during the Plan Year unless there has been a change in your family status (i.e. marriage, divorce, birth, death, adoption, or change in job status for you or your spouse). **Any change must be consistent with, and justified by, the change in your family status.**

- **HOW CAN I ESTIMATE MY EXPENSES FOR THE ENTIRE PLAN YEAR?**

  Contact your dependent/child care provider to assist you in estimating your costs for the entire Plan Year. **Very Important**- When estimating your annual expenses, keep in mind that you may not have the same expenses year-round (i.e. summer months, spring break or holidays). For a complete description of eligible expenses, see IRS Pub 503. ***The maximum annual amount for contributions into a Dependent Care Account is $5000 if the employee is married and filing a joint return or is a single parent or $2500 if the employee is married but filing separately.***

- **WHAT HAPPENS IF I OVERESTIMATE AND CAN'T CLAIM ALL MONEY IN THE ACCOUNT?**

  You will lose the money. The same tax law that allows you to participate in this program also mandates that you forfeit any unused money. This is the "**USE IT OR LOSE IT**" provision of the IRS Code. Any amount left in your account unclaimed after the grace period, at the end of a Plan Year, or at your termination, will be forfeited. But, you may still benefit from your tax savings even if you do not use all the money in your account. (***It is very important that you estimate your expenses carefully and conservatively.)***

- **HOW DOES THE PLAN WORK?**

  You must estimate your expenses for the entire Plan Year and agree to have your salary reduced by that amount on a monthly basis. The money is deposited in a Flexible Spending Account.

  After you have incurred an expense, you must submit a claim form and attach the dependent/ child care receipt or bill. The receipt must show the amount paid, the provider name and EIN or SSN and the dates the expenses were incurred. Claims must be incurred during the Plan Year for which you are enrolled.

  You may file claims at any time during the Plan Year. Claims not received prior to the claim filing deadline will be processed during the following claim payment cycle. A reimbursement check or direct deposit (if available) will be issued to you. The dependent/childcare reimbursement check will be for qualified expenses claimed up to the amount, which is available in your account. You will have a run-out period at the end of the Plan Year to file receipts for reimbursement of expenses incurred during the just completed Plan Year, or incurred prior to your termination.

PLANNING WORKSHEET
FOR
DEPENDENT CARE REIMBURSEMENT ACCOUNT

It is important to note that The Internal Revenue Service (IRS) will not allow you to receive the tax benefits of the Cafeteria Benefit Plan *and* receive the Federal Dependent/Child Care Credit on your tax return for the same dollars. You may find that the Dependent Care Reimbursement Account will save you a considerable amount of money. You may want to consult a tax consultant for more information.

Please use this worksheet to make the comparison between the FEDERAL CHILD CARE CREDIT and the CAFETERIA PLAN TAX SAVINGS.

■ FEDERAL CHILD CARE CREDIT	YOUR CALCULATIONS
1. Your Annual Gross Compensation 2. Your Spouse's Annual Gross Compensation 3. Total Employee and Spouse Income	1. $_____ 2. + $_____ 3. = $_____
4. Number of Qualifying Children 5. Total Child Care Expenses (Annual) Maximum Allowable Expenses 1 Child = $3,000 2+ Children = $6,000/Year	4. _____ 5. $_____
6. From the **Table*** (below), find the gross income that is closest to your total income and put the applicable percentage in the blank provided.	6. _____ %
To Calculate: 7. Child Care Expenses 8. Percentage 9. Your approximate *Federal Child Care Credit*	7. $_____ 8. + _____% 9. = $_____
■ CAFETERIA PLAN DEPENDENT / CHILD CARE TAX SAVINGS	YOUR CALCULATIONS
To Calculate: 1. Total Child Care Expenses (Annual) 2. Your Tax Rate (per prior yr. Income Tax Return) 3. Your approximate *Cafeteria Plan Tax Savings*	1. $_____ x 2. _____% = 3. $_____

IF your adjusted gross income is:		
Over:	But not over:	THEN the percentage is:
$0	$15,000	35%
15,000	17,000	34%
17,000	19,000	33%
19,000	21,000	32%
21,000	23,000	31%
23,000	25,000	30%
25,000	27,000	29%
27,000	29,000	28%
29,000	31,000	27%
31,000	33,000	26%
33,000	35,000	25%
35,000	37,000	24%
37,000	39,000	23%
39,000	41,000	22%
41,000	43,000	21%
43,000	No limit	20%

Health Savings Account (HSA)

- **WHAT IS A HEALTH SAVINGS ACCOUNT FOR WHICH CONTRIBUTIONS CAN BE MADE UNDER THIS PLAN?**

A Health Savings Account ("HSA") is a personal trust or custodial account established with a Custodian or Trustee to be used for reimbursement of "eligible medical expenses" incurred by the Account Beneficiary and his/her tax dependents, as set forth in Code Section 223. The HSA is administered by the HSA Custodian or Trustee or its designee subject to the terms and conditions set forth in the Custodial or Trust Agreement between the Account Beneficiary and the Custodian or Trustee. The HSA is not an employee benefit plan sponsored or maintained by the Employer. The Employer's role with respect to the HSA is limited to making contributions through this Plan to the HSA established by you with the Custodian/Trustee (through Employer contributions and/or pre-tax salary reductions elected by you). The Employer has no authority or control over the funds deposited in your HSA. As such, the HSA identified in the Summary Plan Description and offered through this Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

- **WHO IS ELIGIBLE FOR HSA CONTRIBUTIONS UNDER THIS PLAN?**

HSA eligibility is determined under IRS rules and the applicable terms and conditions of any Custodial or Trust agreement. You are eligible for Plan contributions to your HSA during any month if you satisfy the following conditions on the first day of that month:

(a) You are covered under a qualifying High Deductible Health Plan (as defined in Code Section 223) maintained by Employer;

(b) You certify, in accordance with policies and procedures established by the Employer, that you satisfy all of the requirements to be an Eligible Individual as set forth in Code Section 223. You are required to notify the Employer if you fail to satisfy these conditions on the first day of any month following the date that you first certify that you meet these requirements. In addition to being covered under a qualifying High Deductible Health Plan maintained by Employer, you must not be (i) covered under any other health plan or program that is not a qualifying High Deductible Health Plan (as defined in Code Section 223) unless that coverage is limited to "permitted coverage," "permitted insurance" and/or preventive care as defined in Code Section 223 and related guidance; (ii) entitled to Medicare; or (iii) eligible to be claimed as a Dependent of any other taxpayer.

(c) You are otherwise eligible for this Plan.

- **WHO IS AN ACCOUNT BENEFICIARY?**

An Account Beneficiary is an eligible Participant who has properly enrolled in their own HSA in accordance with the terms of the applicable Custodial Agreement.

- **WHO IS A CUSTODIAN OR TRUSTEE?**

The Custodian or Trustee is the entity with whom the Account Beneficiary's HSA is established (for purposes of this Plan, use of the term "Custodian" includes a reference to both Custodian and Trustee). The HSA is established pursuant to an agreement ("Custodial Agreement") between the Custodian and the Account Beneficiary. To the extent the Participant is an Eligible Individual as defined above, the Participant may establish an HSA with any Custodian; however, pre-tax HSA contributions and Employer HSA contributions, if any, that are made through this Plan will only be made to a Custodian designated by the Employer ("Designated Custodian"). The Participants who establish HSAs with the Designated Custodian will be permitted to rollover funds from the HSA offered through his Plan to another HSA chosen by the Account Beneficiary (in accordance with the terms of the Custodial Agreement).

- **WHAT ARE THE RULES REGARDING CONTRIBUTIONS MADE TO AN HSA UNDER THE PLAN?**

Contributions made under this Plan may consist of both pre-tax contributions made by you through this Plan and/or non-elective Employer contributions (if any) made through this Plan. You may elect to contribute any amount to the HSA up to the annual contribution limit established under Code Section 223 (the "Maximum Annual Contribution Amount"). The Maximum Annual Contribution Amount for an HSA offered under this Plan cannot exceed the sum of the "monthly limits" for each month during the Plan Year that you are an Eligible Individual (as described in Q-2 above). The monthly limit is 1/12 of the lesser of (i) the statutory annual contribution amount established by Code Section 223 for the applicable level of coverage or (ii) such amount established under this Plan, for each month that you are an eligible individual. **NOTE: There is a special rule for employees who become an Eligible Individual during the calendar year. If you are not an Eligible Individual (as defined in above) for the entire calendar year but you are an Eligible Individual during the last month of the calendar year, then you are treated as being an Eligible Individual for the entire calendar year. For all months during the calendar year that you are treated as being an Eligible Individual solely as a result of this rule, you are considered as having the same coverage in effect in the last month of that year. You will be taxed on any contributions made to the HSA (and be subject to a 10% excise tax; such tax increases to 20% effective January 1, 2011) under this rule for months that you were not an Eligible Individual if you cease to be an Eligible Individual during the "Testing Period". The testing period begins in December of the year in which you became an Eligible Individual and ends the last day of December of the following year.**

The Maximum Annual Contribution amount will be prorated equally over the remaining pay periods following your effective date of coverage. No contributions will be withheld until you have provided evidence deemed sufficient by the Plan Administrator that you have established an HSA as set forth herein. If you are or will be age 55 or older before the end of the year and you properly certify your age to the Employer, the Maximum Annual Contribution amount described above may be increased by the "additional annual contribution" amount (as set forth in Code Section 223(b)(3)), but only to the extent permitted in the separate written HSA material provided by the Employer and/or the Custodian.

Employer Contributions are not mandated but if made, such contributions may be made at any time during the Plan Year in a lump sum amount or through periodic contributions (as determined in the sole discretion of the Employer and as communicated in Plan or HSA enrollment materials).

Your election to make HSA contributions through this Plan will not be effective until the later of the date that you make an HSA contribution election through this Plan (to the extent such election is approved by the Plan Administrator) or the date that you establish an HSA with the Custodian during the Plan Year (the effective date of the HSA is determined by the Custodian and/or applicable law). Employer may adjust contributions made under this Plan as necessary to ensure the Maximum Contribution Amount described above is not exceeded.

Any pre-tax salary reduction contributions that cannot be made to the HSA because it is determined that you are not an Eligible Individual (as described in Q-2 above), you have failed to establish an HSA with the Designated Custodian by December 31 (or such other date as determined by the Employer), or that the Maximum Annual Contribution amount has been exceeded will be returned to you as taxable compensation or as otherwise set forth in the Plan or Plan enrollment material. Any Employer Contributions that cannot be made to the HSA because you are not eligible for such contributions will be returned to the Employer except as otherwise set forth in the Plan or the Plan enrollment material.

Employer may advance contributions to you up to your annual HSA pre-tax salary reduction election made through this Plan (reduced by any prior pre-tax contributions made by you during the Plan Year) or such other amount established by the Employer, whichever is less. Advance contributions will be made available to all Participants on non-discriminatory terms and conditions; however, the Employer may condition the advance of such contributions on the occurrence of certain events identified by the Employer in separate written material relating to the Plan. Moreover, you will be required to repay the Employer for advances made through this Plan through means established by the Employer.

In the event excess contributions are made to the Participant's HSA (i.e. the HSA has received contributions in excess of the Maximum Annual Contribution Amount), it will be the sole responsibility of the Participant to work with the Custodian to remove the excess contribution (plus earnings on such contributions) prior to the due date of the Participant's tax return for that tax year and to report the contributions (and earnings) as income when filing taxes at the end of the year. If excess funds are not removed by the tax-filing deadline, you may be subject to tax penalties and/or IRS fees.

2015 IRS Limits		
	Single Plan	**Family Plan**
Maximum Contribution Limit	$3,350	$6,650
Minimum Deductible	$1,300	$2,600
Maximum Out-of-Pocket	$6,450	$12,900
Catch-Up Contribution (55+)	$1,000	$1,000

Maximum contribution limit represents the maximum amount of tax-free savings you can contribute to your HSA each year. If you exceed this amount, you have until the tax-filing deadline to remove excess funds.

Catch-up contributions of an additional $1,000 can be made by accountholders who meet the qualifications noted below.

- Health Savings accountholder
- Age 55 or older (regardless of when in the year an accountholder turns 55)
- Not enrolled in Medicare (if an accountholder enrolls in medicare mid-year, catch-up contributions should be prorated)

Minimum deductible is the deductible requirement for an HSA-compatible high-deductible health plan (HDHP).

Maximum out-of-pocket is the annual maximum amount of out-of-pocket expenses an HSA-compatible HDHP can require before paying out benefits.

- **PRORATED HSA CONTRIBUTIONS**

  If you do not have HSA-compatible health coverage for an entire calendar year, you must prorate your HSA contributions to avoid tax penalties.

- **MID-YEAR COVERAGE**

  If your HSA-compatible coverage begins in July, you can contribute the maximum amount for that year provided you maintain coverage until December 31st of the following year.

- **HEALTH PLAN STATUS CHANGE**

  If you begin the year with family coverage and switch to single coverage in July of that year, you are eligible to contribute half of the family coverage contribution maximum and half of the individual coverage contribution maximum.

- **WHERE CAN I GET MORE INFORMATION ON MY HSA AND ITS RELATED TAX CONSEQUENCES?**

  For details concerning your rights and responsibilities with respect to your HSA (including information concerning the terms of eligibility, qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA Custodial Agreement and/or the HSA communication material provided by your Employer.

SECTION 125 CAFETERIA PLAN
MEDICAL &/OR DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS
FOR
SCHERTZ-CIBOLO-UNIVERSAL CITY ISD
PLAN YEAR SEPTEMBER 1, 2015 – AUGUST 31, 2016

National Plan Administrators, Inc. was selected by your Employer to administer your Flexible Spending Accounts (FSAs) for this Plan Year. The following information is designed to assist you in filing claims. If at any time you have questions about your FSA or related procedures, please call NPA, (800) 880-2776.

CLAIM FORMS:

Attached you will find the forms to be used for submitting claims. Forms are available online at www.natlplan.com/employees.html

Submitted claim forms must be complete, and itemized receipts for the expenses being claimed must be attached to the claim form. *NOTE: a cancelled check or cash register receipt does not suffice*. All claim forms must be signed and dated.

Please see the attached *Claims Submission Procedures* page for more detailed information on this process.

DEADLINE FOR FILING CLAIMS:

Claims will be processed on the 23rd of each month. Claim forms must be received by 3:00pm of that day at National Plan Administrators, Inc. to be processed. Claims received after 3:00pm will be processed the following month. Claim submission via:

Mail: NPA, P. O. Box 161630, Austin, TX 78746
Fax: (800) 982-8140
Email: 125@natlplan.com

You will have 90 days after the end of the plan year (**or until November 30, 2016**) to submit claims against any remaining funds in your account. In compliance with IRS Cafeteria Plan Guidelines, any money remaining in your account after the 90-day claim filing run-out period will be forfeited to the Plan.

REIMBURSEMENT DATES:

We encourage participants to have their reimbursement checks direct deposited. Please complete the enclosed *Direct Deposit Authorization Agreement* form and return it to National Plan Administrators, Inc.

If you elect to have your check mailed to you, it will be sent to your home address. Therefore, please make sure your address is printed clearly on your claim form.

NATIONAL PLAN ADMINISTRATORS, INC. (NPA)
CLAIM SUBMISSION PROCEDURES

According to the Internal Revenue Code Section 125, the Unreimbursed Medical and Dependent Care Flexible Spending Accounts (FSAs) may reimburse an expense if the participant provides

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred,
- The amount of such expenses(s)
- The participant must also sign a statement that the medical/dental expense has not been reimbursed or is not reimbursable under any other health plan coverage.

Unreimbursed Medical Claims will be reimbursed up to the amount elected for the Plan Year.

Dependent Care Claims will be reimbursed according to the amount available in your spending account at the time your claim is processed.

Orthodontia Claims will be reimbursed according to the amount available in your spending account at the time your claim is processed.

Listed below are procedures for submitting claims that will help to ensure prompt and efficient processing of a participant's claim:

1. Make sure that your Request for Reimbursement Form is COMPLETED and SIGNED. Please do not highlight any areas of the claim form so the forms can be legible. It is important to note that the date of service, not the date of payment, must fall within the Plan Year for which you are enrolled.

2. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a receipt, EOB, etc.) associated with each expense that indicates the following :
   - Name of person receiving service
   - Name and address of service provider
   - Nature of service or supplies. If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy with the RX number; and
   - Total amount of payment for which you are seeking reimbursement

3. All receipts submitted for *Dependent Care expenses* must include the name(s) of the person(s) for whom the service was provided, the actual date(s) of service, a breakdown of all charges, the care giver's signature, along with the care giver's tax identification number or social security number.

4. When filing orthodontic claims for the first time, NPA must have *a copy of the Orthodontic Contract* including the down/initial payment, schedule of payments, when banding will occur and the duration of the treatment. Thereafter, simply submit a claim form with the receipts and indicate that it is an orthodontic treatment expense. Claims can only be reimbursed for payments made according to the orthodontic contract payment schedule.

5. Please be sure to retain copies of originals of all items submitted to NPA for reimbursement.

MEDICAL REIMBURSEMENT REQUEST FORM

Employee Name: _____ **SS#:** _____ **Employer Name:** _____

Employee Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employee Home Phone: _____ **Employee Work Phone:** _____

INSTRUCTIONS: Use this form to request reimbursement for all eligible medical expenses whether paid by debit card, cash or check. Sign and date the form and submit to Nation Plan Administrators (NPA). Fill in all the information requested below for medical expenses incurred by you, your spouse, or your eligible dependent.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Service Actually Provided	***09/01/15***				
Name of Person Receiving Medical Service & Relationship to You	**Fred Jones** Self Spouse Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Type of Service (Office Visit Co-pay, Dental, RX, Vision, etc)	***Dental***				
Total Expense	***$100.00***	$	$	$	$

Total Amount Claimed: $	

To the best of my knowledge and belief, my statements in this Medical Reimbursement Request Form are complete and true. I certify that the services described above were received on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any federal income tax deduction or credit. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance shall remain with the employer at the end of the Plan Year.

Employee Signature _____ Date _____ Email Address _____

NATIONAL PLAN ADMINISTRATORS, INC
P.O. BOX 161630
AUSTIN, TX 78716
PHONE: (512) 327-6481 or (800) 880-2776
FAX: (512) 275-9396 or (800) 982-8140
Email: 125@natlplan.com
WEBSITE:www.natlplan.com

IRS Code Section 213(d) Eligible Medical Expenses

An eligible expense is defined as those expenses paid for care as described in **Section 213 (d)** of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible.

For more detailed information, please refer to **IRS Publication 502** titled "Medical and Dental Expenses." If tax advice is required, you should seek the services of a competent professional.

Deductible Medical Expenses

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Birth control Pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian science Practitioner
- Contact Lenses
- Contraception devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addition therapy
- Drugs (prescription)
- Elastic Hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care services
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal Care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Non-Deductible Medical Expenses

- Advanced payment for services to be rendered next year
- Athletic club membership
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Bottled water
- Commuting expenses of a disabled person
- Cosmetic surgery and procedures
- Cosmetics, hygiene products and similar items
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Maternity clothes
- Non-prescription medication
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Scientology counseling
- Social activities
- Special foods and beverages
- Specially designed car for the handicapped other than an autoette or special equipment
- Stop-smoking programs
- Swimming pool
- Travel for general health improvement
- Tuition and travel expenses a problem child to a particular school
- Weight loss programs

Eligible Over-the-Counter Drugs

(A doctor's prescription is required before eligible over the counter drugs and medications can be reimbursed.)

- Antacids
- Allergy Medications
- Pain Relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Sinus Medications and Nasal sprays
- Nicotine medications and nasal sprays
- Pedialyte
- First aid creams
- Calamine lotion
- Wart removal medication
- Antibiotic ointments
- Suppositories and creams for Hemorrhoids
- Sleep aids
- Motion sickness pills

Ineligible Over-the-Counter Drugs

- Toiletries (including toothpaste)
- Acne treatments
- Lip balm (including Chapstick or Carmex)
- Cosmetics (including face cream and moisturizer)
- Suntan lotion
- Medicated shampoos and soaps
- Vitamins (daily)
- Fiber supplements
- Dietary supplements
- Weight loss drugs for general well being
- Herbs

DEPENDENT CARE REIMBURSEMENT REQUEST FORM

Employee Name: _____ **SS#:** _____ **Employer Name:** _____

Employee Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employee Home Phone: _____ **Employee Work Phone:** _____

INSTRUCTIONS: Use this form and fill in all the information requested below to request reimbursement for eligible dependent care expenses.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Dependent Care Service Provided	**09/01/15 to 09/30/15**				
Name and Age of Dependent	**Fred Jones Age 4**	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Name and Address of Provider & TIN# or SS#	**Day Care Inc. 123 Main St. Anytown, TX TIN# 74-12345**				
Total Expense	**$250.00**	$	$	$	$
Reimbursement Requested	**$250.00**	$	$	$	$

Total Amount Claimed: $	

To the best of my knowledge and belief, my statements in this Medical Reimbursement Request Form are complete and true. I certify that the services described above were received on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any federal income tax deduction or credit. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance shall remain with the employer at the end of the Plan Year.

_____ _____ _____

Employee Signature Date Email Address

NATIONAL PLAN ADMINISTRATORS, INC
P.O. BOX 161630
AUSTIN, TX 78716
PHONE: (512) 327-6481 or (800) 880-2776
FAX: (512) 275-9396 or (800) 982-8140
Email: 125@natlplan.com
WEBSITE:www.natlplan.com

QUALIFYING DEPENDENT CARE EXPENSES

The Section 125 Cafeteria Plan Document contains the rules governing what expenses are covered. By signing and submitting this Dependent Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet all the following conditions:

1) The expenses are incurred so you (and your spouse, if you are married) can work or look for work.
2) The amount of the reimbursement requested, when aggregated with all other reimbursements received by you under the Plan during the same calendar year, do not exceed the lesser of:
   (A) your earned income; or
   (B) If you are married, your spouse's actual or deemed earned income.
3) Each dependent for whom you incur the expenses is:
   (A) a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return, or
   (B) Your spouse or a person who is your dependent under federal tax law (even if you may not claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of caring for him or herself.
4) The expenses are incurred for the care of a dependent, or for related incidental household services.
5) If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 3(A) above (or who is described in 3(B) above and regularly spends at least 8 hours per day in your household).
6) If the expenses are incurred for services provided by a dependent care center (i.e. a facility that provides care for more than 6 individual not residing at the facility), the center complies with all applicable state and local laws and regulations. Expenses are not paid for services at a camp where the dependent stays overnight.
7) The person who provided care was not your spouse or a person whom you can claim as a tax dependent. If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.

PROCEDURE FOR SUBMITTING A CLAIM

Section 125 of the Internal Revenue Code stipulates the requirements for an expense to be reimbursed under a Dependent Care Reimbursement Account (DCA).

1) The expense must be an eligible expense.
2) There must be documentation from an independent provider that the expense was incurred. Itemized statements, receipts and bills are acceptable documentation. Canceled checks, adding machine tapes, and credit card statements are not acceptable. The documentation must include:
   - Date(s) of service,
   - Name(s) of the person(s) for whom the service was provided,
   - A breakdown of all charges or services,
   - Provider's name, address and signature,
   - Provider's tax identification number or social security number,
   - Total amount of payment for which you are seeking reimbursement.
3) There must be a signed statement that the expense has not been previously reimbursed and is not reimbursable under any health plan.
4) Dependent care claims will be reimbursed up to the balance available in the claimant's Dependent Care Account at the time a claim is processed.
5) There will be no reimbursement of dependent care before the care has been incurred even if payment has been made in advance. Dependent care claims will only be reimbursed **after** the care has been incurred.

NOTES: Dependent Care Reimbursement Request Forms are available on line at www.natlplan.com/employees.html

Please keep a copy of all records submitted to NPA.

NATIONAL PLAN ADMINISTRATORS, INC.

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I (we) hereby authorize National Plan Administrators, Inc. hereinafter called "Company" to initiate credit entries to my (our) account indicated below at the depository financial institution named below, hereinafter called "Bank," and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U. S. law.

Company Name: National Plan Administrators, Inc.

Company Address: 1101 Capital of TX Hwy South, Bldg. E, Suite 100, Austin, TX 78746

Employee Name: _____ **Employer/District:** _____

Employee Address: _____ **SS#:** _____

Name(s) on Bank Account: _____

Account Number: _____ **Please indicate one:** ☐ **Checking** ☐ **Savings**

Bank Name: _____ **Bank's Routing/transit No.:** _____

Bank Address: City, State, Zip: _____

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

My email address is: _____

Please Attach Voided Check Here

Authorized Signature: _____ **Date:** _____

(Signature must match signature card on account.)

Phone: (800) 880-2776 Fax: (800) 982-8140 P. O. Box 161630 Austin, TX 78716

PARTICIPANT PORTAL ONLINE ACCOUNT ACCESS

Your Section 125 Cafeteria Plan with Schertz-Cibolo-Universal City ISD allows you to have access to your Medical and/or Dependent care Reimbursement account on line. Please visit our benefits website **www.benefitspaymentsystem.com** and select **Participant Login** to create and access your account.

- Select *Create an Account*.
- You will enter your First and Last name.
- Your Employee ID is your social security number (no dashes).
- You will enter **NPASCHERTZ** as the Employer ID
- New User ID - Enter a User ID to identify you to the system
- Password – must contain between 8 and 16 characters; at least one instance of a lower case letter, upper case letter, and a number.
- Enter Security Word (Mother's Maiden Name)
- Enter Birth City
- Enter your email address
- Select Submit

At this point you should be able to log back in with your User ID and password information. Access to the Portal allows a participant to view such information as current balances, pending claims, deposits, and the ability to download additional claim forms.

If assistance is needed in accessing your account, please do not hesitate to contact the Section 125 Cafeteria Plan Department:

PHONE: (512) 327-6481 or (800) 880-2776
FAX: (512) 275-9396 or (800) 982-8140
Email: 125@natlplan.com

Health FSA Debit Card Summary

How does the Electronic Payment (Health FSA) Debit Card work?

(a) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible Expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available in your Health FSA account. Every time you swipe the Card, you certify to the Plan that the expense for which payment under the Health FSA is being made is an eligible medical expense, that you have not been reimbursed from any other source and you will not seek reimbursement from another source.

(b) *You must obtain and retain a receipt/third party statement each time you swipe the card.* You must obtain documentation from the merchant (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:

- The nature of the expense (i.e., what type of service or treatment was provided)
- The date the expense was incurred
- The amount of the expense.

Even though payment is made under the card arrangement, documentation may be required for substantiation. You will receive a notification from the Plan Administrator if documentation is needed.

(c) *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

Is there an additional cost to me, as a participant, for having a Health FSA Debit Card?

Yes, there is a $12.00 annual fee for those who elect a debit card. This fee is deducted from your total annual election and reduces your available balance at the beginning of the plan year. This fee is non-refundable.

How do I pay for Orthodontic Care using the Health FSA Debit Card?

Per your employer's Plan Amendment effective September 1st, 2011 all Orthodontia Accounts are payroll based, not pre-funded. The amount available on your card will not exceed the year-to-date amount credited to your Orthodontia Account through payroll contributions, less any prior reimbursements. Thus, at point-of-sale, you must request your debit card to be processed for the exact amount available in your account; otherwise, your card will be declined.

What are qualified medical expenses?

Qualified expenses are expenses for medical services not covered by the health care plans: deductibles, prescription and physician co-pays, vision, dental, orthodontia, chiropractic, and acupuncture services are some examples.
*For a full explanation of 'qualified' and 'non-qualified, please refer to the list included in your Summary Plan Document.

What happens if I use the card to purchase a 'non-qualified' expense?

If it is determined that your Flex Debit Card was used for the purchase of a 'non-qualified' expense or a payment was made for a service outside of your plan year dates, the amount will have to be repaid by you to National Plan Administrators within the same plan year the expense was incurred.

What if I pay a recurring medical expense?

If the payment is made at the same provider for the same recurring amount, you will be asked to submit documentation for substantiation. Once approved, you will need to contact your Plan Administrator so that your card can be set up to automatically recognize and approve said expense as to not be prompted to submit documentation.

What if my Electronic Payment Debit Card is declined?

Your debit card will not work if:

- You do not have enough funds in your flexible spending account to cover the total cost of the transaction.
- You received care or treatment from a provider whose Merchant Category Code is a non-medical provider type.
- You selected "debit" after you swiped your card. Even though it is a debit card, always choose the "credit" option.

What if I have multiple Flex accounts (Medical, Ortho)?

One card will be issued to you. The debit card system is capable of deciphering which purchase pertains to which account. For a spouse or dependent, an additional card can be ordered along with a $5.00 fee per additional card.

What happens if my card is lost or stolen?

Please contact your Plan Administrator at 1-800-880-2776 to report the loss of your card.

At the end of the plan year:

Schertz-Cibolo-Universal City ISD's plan allows 90 days after the end of the plan year to submit claims towards any remaining account balances. However, on August 31st, 2016, all cards will be inactive for the 2015-16 plan year and will be set to recognize the future plan year dates. Therefore, manual claims must be submitted in order to claim any remaining funds.

When a participant terminates employment or coverage:

The card will be turned off when you terminate employment or coverage under the plan. You must submit a manual claim no later than sixty days after your termination date in order to receive any remaining account funds.

Who can I contact if I have any questions?

If you have questions about using the card, please contact National Plan Administrators 125 Flex Cafeteria Department at 125@natlplan.com or call 1-800-880-2776.

MANDATED HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR PERSONAL AND HEALTH INFORMATION IS IMPORTANT.
THIS REQUIRES NO ACTION ON YOUR PART UNLESS YOU HAVE A REQUEST OR COMPLAINT.

■ **National Plan Administrator's Pledge Regarding Medical Information**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for administration purposes. This notice applies to all of the medical records we maintain.
Both under law, The Health Insurance Portability and Accountability Act (HIPAA) and our policy, National Plan Administrators, Inc (NPA) has a responsibility to protect the privacy of your personal and health information, which is legally known as Protected Health Information (PHI). We: protect your privacy by limiting who may see your PHI; limit how we may use or disclose your PHI; inform you of our legal duties with respect to your PHI; explain our privacy policies; and strictly adhere to the policies currently in effect.
This notice takes effect on 4/14/2003 and will remain in effect until we replace it and provide you notice of such changes.

■ **NPA's Uses and Disclosures of Plan Member's PHI**

As a Plan member, NPA may use and disclose your PHI, without your consent/authorization, in the following ways:

Treatment: We may disclose your PHI to a doctor, a hospital or other entity that asks for it in order for you to receive medical treatment.

Payment: We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations: We may use and disclose medical information about you for Plan operations that are necessary to run the Plan. We may use medical information in connection with: conducting quality assessment and improvement activities, medical review, legal services, audit services, fraud and abuse detection programs; business planning and development, such as cost and business management and other general Plan administrative activities or other activities relating to Plan coverage such as enrollment, changes or disenrollment in Plan.

Disclosure to Health Plan Sponsor: Information may be disclosed to another health plan maintained by your employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to your employer solely for purposes of administering the Plan.

Disclosure to Business Associates: We will share your PHI with third party "business associates" that perform various activities for the Plan. Whenever an arrangement between NPA and a business associate involves the use or disclosure of your PHI, NPA will have a written contract that contains terms that will protect the privacy of your PHI.

Required by Law: We must use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

Process and proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose limited information to law enforcement officials concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution.

Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

■ **Authorizing Use and Disclosure of Plan Member's PHI**

NPA will request written authorization from you to use your PHI or to disclose it to anyone for any purpose or situation not included in this document. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your PHI for any reason except those described in this notice without your written authorization.

■ **Individual Rights for All Plan Members**

As a Plan member, the following are your rights concerning your PHI:

Access: You have the right to review or obtain copies of your PHI, with certain exceptions. If you request copies, NPA may charge you a fee for each page, and a per hour charge for staff time to locate and copy your PHI, and postage to mail it.

Disclosure Accounting: You have the right to request in writing a list of instances in which NPA or our subcontractors disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities. Your request must state a time period no longer than six years and not before April 14, 2003. If you request this list more than once in a 12-month period, NPA can charge you a fee.

Amend: You have the right to request in writing that we amend your PHI if you feel the information we have about you is incorrect or incomplete. You must explain why the information should be amended. We may deny your request if we did not create the information you want amended, in the first place or we do not even maintain or keep the information in question, or the information is in fact accurate and complete.

Restriction Request: You have the right to ask us not
to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested
and to whom you want the restriction to apply.

Alternate Confidential Communications: We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method
of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

If You Have a Complaint: If you are concerned that NPA may have violated your privacy rights, you may file a complaint. You may also submit a written complaint to the Secretary of the Department of Health and Human Services. NPA will not retaliate in any way if you choose to file a complaint. If you want more information regarding our privacy practices or would like to request a form, you may contact us in the following ways:

■ Email: privacyofficer@natlplan.com ■ Access us at: www.natlplan.com

■ National Plan Administrators, Inc., Privacy Officer
P.O. Box 161630, Austin, TX 78716

■ Phone: (800) 880-2776 x263 Fax: (800) 982-8140

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. A current copy of this notice will be posted on the NPA website.